S. HRG. 101-1059

LONG-TERM CARE FOR THE NINETIES: A SPOTLIGHT ON RURAL AMERICA

HEARING

BEFORE THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

ONE HUNDRED FIRST CONGRESS

SECOND SESSION

LITTLE ROCK, ARKANSAS

AUGUST 21, 1990

Serial No. 101-27

Printed for the use of the Special Committee on Aging

U.S. GOVERNMENT PRINTING OFFICE

35-254 WASHINGTON : 1990

For sale by the Superintendent of Documents, Congressional Sales Office
U.S. Government Printing Office, Washington, DC 20402

S141-5

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LONG-TERM CARE FOR THE NINETIES: A SPOTLIGHT ON RURAL AMERICA

TUESDAY, AUGUST 21, 1990

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Little Rock, AR.

The committee met, pursuant to notice, at the Gilbreath Conference Center, Baptist Medical System, Senator David Pryor presiding.

Present: Senator Pryor.

Also present: Portia Porter Mittelman, staff director; Christine Drayton, chief clerk; Kristine Phillips, press secretary; Holly Bode, professional staff; Bonnie Hogue, professional staff; Heather Dreyer, professional staff; Anna Kindermann, professional staff; John Monahan, professional staff; Johnna Goggans, press assistant; Marcia Lecky, legislative correspondent; and Ann Dixon, legislative correspondent.

OPENING STATEMENT OF SENATOR DAVID PRYOR

Senator PRYOR. Ladies and gentlemen, good morning, and we welcome you to this hearing of the Special Committee on Aging of the U.S. Senate from Washington, DC. We thank especially those witnesses who have come this morning to share with us not only human experiences, but also their own expertise in dealing with many of the problems that we're going to discuss this morning.

We would like to state that this hearing, although it is long-term care for the 1990's, will spo1tlight specific concerns of the elderly in rural America. I'd like to begin by thanking all of you, once again, for coming. I want to thank the staff who have made this possible. And I would like to first thank the Baptist Medical System and Mr. John Pounders for making this room available to us. John, please take a bow over here, and let's give John Pounders a round of applause. Thank you, John.

Some of these issues today are very complex and some people say that long-term care should focus on institutional care or nursing home care. Others believe that the focus should be on addressing transportation needs or preventative care measures. They think that these are the most important components. Still others maintain that long-term care should be primarily concerned today with controlling the high cost of prescription drugs and other medical necessities.

Well, I believe in a comprehensive definition of long-term care. I think it should incorporate all of these things and more. Long-term

care is, in fact, all of these services, above and combined, required by the person who is functionally disabled. Last year, the Senate Aging Committee, jointly with the Pepper Commission, held a hearing in Little Rock which addressed the need for access to all types of health care for the elderly and also the uninsured. Today, we are, in a sense, following up on last year's hearing by focusing on long-term care and rural America while expanding our definition of long-term care services.

Witnesses who have gathered with us today—they're all very busy, we appreciate once again them coming—come from all over the State to share their experiences. This hearing would not be possible without the assistance of such dedicated individuals. In addition, let me extend a special thanks for those who have been instrumental in the development and who have been so cooperative in helping us prepare this hearing: Herb Sanderson, Arkansas Division on Aging; Dixie Clark, Executive Director of the Central Arkansas Area Agency on Aging; Scott Holladay, Arkansas Seniors Organized for Progress; James Loftis, Services and Opportunities for Seniors, called SOS; Donald Hollingsworth, Central Arkansas Legal Services; and of course, John Pounders and the Baptist Medical System.

One thing that I have been particularly concerned and worried about and, in fact, angered about, are the very high prices and the skyrocketing increase in the cost of prescription drugs. I don't know how many of you have been to the drug store lately to pick up your prescription drugs. But I can tell you without reservation, and I think without exception, you are seeing increases rather than decreases. You are seeing no drugs really basically stay the same to any degree, and most drugs today are going up by enormous magnitude. Drug costs represent the highest out-of-pocket expense for three of four older Americans. Over 15 percent today of the elderly report that they cannot afford the medications that they need.

To respond to this very critical concern, I have introduced Senate Bill 2605, which is called the Pharmaceutical Access and Prudent Purchasing Act of 1990. The goal of this legislation is two-fold: To assure in many cases access to needed medications, and to provide the Medicaid Program the saving it deserves. My proposal asks for nothing more than the fair pricing of prescription drugs. I might just add that the pharmaceutical manufacturers are fighting this legislation with every resource at their command. They have hired the very top law firms and the most expensive lobbying firms in and around Washington, DC to oppose S. 2605.

Also, we are examining services authorized under the Older Americans Act for possible legislative options in the 1991 reauthorization process. The transportation concerns of the elderly, one of the many social services provided for under the Act, this is particularly a significant issue today because those living in rural areas where the closest grocery stores, pharmacies, or medical facilities may be miles away.

As I chair the Aging Committee of the U.S. Senate, I want you to know that I am dedicated, as are all the members of that committee, to improving the lives of senior citizens. My staff and I have already been involved over this last year and a half in a wide range of concerns, including those issues of Social Security, medi-

gap, and the fraud being practiced against the elderly attempting to sell medigap policies, insurance counseling, biomedical research, nursing home reforms, to name just a few. As each issue is addressed, we are making a step toward the ultimate goal of enabling older Americans to live independent, productive lives with their dignity intact.

There are so many elderly Arkansans whose stories, human stories, cry out today to be told, not only to this State but to America. Many of these citizens wanted to be with us today but were simply too frail or lacked the resources to travel. Therefore, some very ingenious and creative members of the Aging Committee staff have basically gone out to the people. They have been in two communities in our State in the last 10 days. One is Stephens, AR, and one is Paragould, AR. As a result, they have made a film. I have not actually seen this film. It is 8 minutes. It is entitled "Growing Old in Rural America: Is Dignity the Price?"

The very special and final word of thanks to the Arkansas Education TV Network, AETN, for their assistance in making the production of this video possible. Also thanks to KARK Channel 4, and the Storer Cable Company, which will broadcast today's proceedings in their entirety tonight at 7 p.m. on the cable access channel, channel 18.

Once again, we thank you. There are comment cards on the front table right outside of this door. We hope if you have not picked up comment cards that you will, and that you will fill out those cards and give us any suggestions that you might have. Portia Mittelman is the Staff Director for the Special Committee on Aging, and we are very proud that she is a native of Little Rock, AR. Portia will be here during the entirety of the hearing and we appreciate Portia and her staff. Now, there are screens placed around the room, and I guess we would say we are getting ready now to watch an 8-minute film and then we will call our first panel of witnesses.

[At this time, the film was played.]

Senator PRYOR. I would like to thank Kris Phillips and Johnna Goggans on the Aging staff for putting that film together, and I think it tells a story that all of us need to know. And we want to thank Kris and Johnna for doing that. That was a very moving film.

We are going to call our first panel this morning. First, there's no stranger to the State of Arkansas, Dr. Joycelyn Elders, who is Director of the Arkansas State Department of Health in Little Rock. Dr. Elders, thank you for coming. Mrs. Pearl Herman, the Advocate, Arkansas Department of Human Services, and Dr. Steven Collier, Medical Director, White River Rural Health Center from Augusta. Dr. Collier, we appreciate you and Mrs. Herman and Dr. Elders.

Dr. Elders, we will ask you to make a statement first. We are going to give Dr. Elders a few additional moments this morning. I am going to ask all the witnesses to make their statements in 5 minutes or less, and then we will put their statements in full in the record. A transcript of this official hearing will be available from the Senate Special Committee on Aging in the very near future. We will keep you posted as to when that is available. Dr. Elders, we thank you for coming. And by the way, we hope you

have your electricity back on at the State Health Department. I noticed last night that the electricity went out and you had to let the employees off, so thank you for coming.

STATEMENT OF M. JOYCELYN ELDERS, M.D., DIRECTOR, ARKANSAS DEPARTMENT OF HEALTH, LITTLE ROCK, AR

Dr. ELDERS. Thank you, Senator Pryor. Senator, members of the Special Committee on Aging, ladies and gentlemen, as Senator Pryor said, I'm Dr. Joycelyn Elders, Director of your State Health Department. I appreciate the opportunity to discuss with you an issue which touches or will soon touch virtually every American citizen: long-term care. The fact that the Senate Special Committee on Aging is holding hearings here today to gather information is itself a statement about the importance of this issue and your concern.

Issues related to long-term care affect all of us. They cross age, race, sex, and economic levels. All of us have to face the dilemma of how to obtain and provide long-term current care services. According to national polls, 80 percent of Americans have or will, within the next 5 years, need long-term care for either themselves, a family member, or a very close friend. The need for long-term care is growing dramatically. The greatest users of long-term care are those over age 85. That population is projected to grow 234 percent between 1980 and the year 2000. Long-term care, as Senator Pryor has said, is more than nursing home care; long-term care encompasses the range of services needed by a person who's functionally dependent, whether in their own home, the home of a family member or, as the last resort, in an institution.

The problem in rural America is further complicated because of health care manpower shortages, health care financing, health care service delivery, and utilization. 14.5 percent of our population is greater than 65 in Arkansas. We have the fifth highest percent of over 85 population in America. When there is a manpower shortage, we know that 60 percent of our physicians are in urban areas, whereas only 39 percent of our population is in urban areas. Therefore, in our rural areas where we have the greatest need, we only have 39 percent of our health care manpower.

The results of our crisis in long-term care can be seen everywhere in our daily lives. First, multitudes of people are forced into nursing homes before they really need to be there. They immediately lose control of their life and lose their dignity as human beings, as was seen on the film. Costs for these services often exceed what would have been spent had they been able to be served in their own home. Simultaneously, families and friends of the long-term care patient give their entire energy and lifesavings toward long-term care, often only delaying the inevitable, poverty and institutionalization.

Finally, we're pitting our elderly against our children in competing for limited Federal resources. Funds should not be diverted from serving our most valuable resource, our young people, who will become the backbone of our society in 20 years.

To me, the long-term care problem can be broken down into three major issues: (1) there is a limited availability of many serv-

ices in the rural area; (2) only the poor can afford these services; and (3) a rapidly growing funding shortage for these services.

First, except for the very, very poor, there simply is not an organized system of services for persons who cannot care for themselves—services which are critical to avoiding placement into nursing homes. Services such as a bath, a meal, a medication reminder, fresh bed linens, light housework, transportation to the doctor, and often desperately needed by our frail on a routine basis. Without assistance, the only option is often nursing home placement. With help, they might stay home a little longer.

The second component of the problem brings about impoverishment of too many Americans who worked all their lives. They end up having to be the recipients of Medicaid. Medicaid is faced with skyrocketing demands for long-term care services to the extent that those demands limit Medicaid's ability to provide the other acute and preventative services. Over a third of our total Medicaid budget in the State of Arkansas, and up to 40 to 50 percent in other parts of our country, is dedicated to nursing home care.

Senator, we've not developed a system for providing long-term care services for our elderly, nor have we developed a system for providing preventative health care. Our health budget is over $660 billion, 12 percent of our gross national product. Ninety percent of that is spent on the last month of life. Only 0.8 percent is spent on prevention.

Perhaps one of the reasons that we're in such a dilemma in long-term care is that until now, we've not focused on long-term care. We've put all of our funds into acute care and episodic care. We must develop a system. We must develop an organized reimbursement system for long-term care. Service development will then come about when there is a system to pay for these services.

To solve the problem, we, as a nation, must develop a broad array of services available without regard to age or income. The services must include nontraditional services. In addition to nursing and personal care aid, transportation to the doctor is important. Regular housekeeping and laundry is critical to those who cannot provide for themselves. Home maintenance can often mean the difference in whether or not a person's home is safe and livable. Having someone available to provide nutritional assessment and counseling for a special diet may be critical. Caregiver relief should be a key element to enable family members to continue to provide the bulk of care for the loved one. Let's face it, this will cost money, which 65 percent of our taxpayers say they are willing to pay.

In conclusion, I feel the long-term care dilemma is one of the Nation's more pressing and growing problems. We in Arkansas have tried to provide some of these services, but we are unable to do all the things we know we need to do. The Nation desperately needs a broad array of services for persons who are functionally dependent, regardless of age or income. We feel that there is support.

Millions of individual tragedies made up the statistics which surround us. Each one of these stories are sad, one which portrays the loss of individual freedom and dignity of a human being, misery, loneliness, and self-pity. We can help our elderly overcome the obstacles to remain independent, a part of the family, a part of the

community, surrounded by the love of their family, and also they are there to help make their family happy, too.

Lastly, Senator, I urge you and your committee to look at the change in demographics of our aging population. Look at the lack of a comprehensive reimbursement system for long-term care. Reassess the failure of our country to institute comprehensive health education programs for all of our citizens. Look at why we fail to provide preventative health measures, and let's try and develop a health care system which will improve both the quality and quantity of life of all Americans. We have the know-how. We have the resources. We need you to help us make this Nation make a commitment for all Americans. Thank you.

Senator PRYOR. Thank you, Dr. Elders.

Dr. Elders, I might tell the audience this morning that last night in preparation for our hearing, I took your resume and I looked at it, and I was overwhelmed at not only the many, many honors that you have received, but also the tremendous amount of training that you have put into your life. And I can only say that this State is very, very fortunate to have someone like you, and we appreciate that.

Dr. ELDERS. Thank you, Senator.

[The prepared statement of Dr. Elders follows:]

Address to the

Special Committee on Aging

United States Senate

by

Dr. Joycelyn Elders

Arkansas Department of Health

Chairman Senator Pryor, Ladies and Gentlemen:

I appreciate the opportunity to discuss with you an issue which touches or will soon touch virtually every American citizen: **Long Term Care**. The fact that the Senate Special Committee on Aging is holding hearings here today to gather information is itself a statement about the importance of the issue, and about your concern.

The issues of long term care affect us all. They cross age, race, and sex, and economic levels. All of us face the dilemma of how to obtain and provide long term care services. According to national polls, 80% of Americans have, or will, within the next five years, need long term care for either themselves, a family member, or a very close friend. And, the need for long term care is growing dramatically. The greatest users of long term care are those over age 85. That population is projected to grow 234% between 1980 and 2000.

Long term care is **more than nursing home care**. Long term care encompasses the range of services needed by a person who is functionally dependent. These services may be provided in the home, or as a last resort in an institution.

THE RESULTS OF OUR PROBLEM

The results of our crisis in long term care can be seen everywhere in our daily lives:

- First, multitudes of people are **forced** into nursing homes before they really need to be there. They immediately lose control of their life, and lose their dignity as human beings. Costs for these services often exceed what would have been spent if they had been served at home.

- Simultaneously, families and friends of the long term care patient give their entire energy and life savings toward long term care, often only delaying the inevitable: poverty and institutionalization

- Finally and as importantly, existing federal funding for long term care is **competing** with funding for preventive health services for children. I know that you are aware of the nation's pressing needs in this area also. Funds should not be diverted from serving our young people who will become the backbone of society in 20 years.

THE PROBLEM

To me, the long-term care problem can be broken down into three problems:

1. A very **limited availability** of some services
2. Only the poor can **afford** the services
3. A rapidly growing **funding shortage** for services.

First, except for the very, very poor, there simply is not an organized system of services for **persons who cannot care for themselves**. Services which are critical to avoiding placement into a nursing home. Such services as a bath, a meal, a medication reminder, fresh bed linens, light housework, and a trip to the doctor, are often desperately needed by the frail on a routine basis. Without assistance, the only option is often nursing home placement; with help **they might stay at home a little longer**.

The second component of the problem brings about the **impoverishment of so many Americans who have worked hard all their lives**. This happens because there has been little or no third party coverage for these services that are so essential to those persons who cannot care for themselves. The only exception is Medicaid.

Persons who are not initially Medicaid-eligiole must bear the cost from their own resources. Their long term care expenses very quickly drain away all of their resources. They are then poverty stricken. Now, Medicaid becomes the payor. But that doesn't stop the fact that the patient has given up his **entire life savings** in athe process.

Thirdly, additional funding may be required for the development of a broad array of services for those who are not very, very poor. The only existing Federal program which reimburses for long term care services, **Medicaid, must also provide other services**.

Medicaid is faced with skyrocketing demands for long term care services, to the extent that those demands limit Medicaid's ability to provide other acute and preventive services. Over a third of the total Medicaid budget in Arkansas is dedicated to Nursing Home care alone. Although most people agree that preventive services for children can be very cost effective, many more such services could be provided if the long term care burden in Medicaid were lessened. And hospital care, physician care, and drug services.

HOW DID WE GET HERE?

Perhaps one of the reasons why we have a long term care dilemma is that, until now, we have focused our attention upon developing acute and episodic health care services. This has meant that third party payors (Medicare, Veteran's Administration, and private insurors) generally cover needed acute services such as hospital, physician, laboratory, ambulance, physical therapy, short-term home nursing, and other health services. Third party coverage for long term care services has **not** been generally not available.

Without the existence of an **organized reimbursement system** for long term care, service development has been, and may continue to be, slow. Many critical services are simply not readily available to the average citizen.

THE SOLUTION:

The solution is not a simple one. The nation needs a broad array of services available **without regard to age or income.**

The services must include **non-traditional services**. In addition to nursing and personal aide services, transportation to the doctor is important. Regular housekeeping and laundry is critical to those who cannot provide that for themselves. Home maintenance can often mean the difference in whether or not a person's home is safe and livable. Having someone available to provide nutritional assessment and counseling for a special diet may be critical. Caregiver relief should be a key element, to enable family members to continue to provide the bulk of care for their loved ones.

Here in Arkansas, we have taken some steps through the Health Department to offer to persons some of the above key services of long term care at home. In addition to the more traditional post-hospital recuperative home health care, we offer personal care services and nursing assessment/teaching to all chronically ill and frail, not just those who are poor. We charge people based on their ability to pay. We provide assistance with personal care, meal preparation, and limited housekeeping, under supervision of a registered nurse. On any given day last week, in addition to the 2500 acutely-ill recovering patients which we served in their homes, we served over 3500 patients who were chronically ill and frail to the point that they could not care for themselves.

But this, while definitely a major improvement for Arkansas, is not the solution. There are thousands more who desperately need services.

Let's face it: the development of additional services will **probably require additional funding**.

What do people think about the nation's obligating added funding to long term care? **Polls have shown that finding a solution to this problem should receive priority over any other national goal.** Secondly, 65% of those polled were willing to pay **additional taxes** if those taxes were directed specifically toward long term care. Public support appears very strong in support of major changes to deal with the issue, even recognizing that such a change may well cost.

CONCLUSION

Mr. Chairman, I want to conclude by reiterating four key points:

1. That the long term care dilemma is one of the nation's more **pressing** and growing proglems;

2. That while we have taken some measures in Arkansas, the solution to the problem must be **broader** than what we are able to do;

3. That the nation desperately needs a broad system of services for persons who are functionally-dependent, **regardless of income or age**.

4. That there appears to be significant support at the **grass roots** level for the type of changes which will be required to deal with the problem.

And I want to conclude by contrasting our current situation with **what could be**:

Millions of individual **tragedies** make up the statistics which surround us. Each one of these stories can be a sad one, one which portrays the loss of individual freedom and dignity of a human being. Misery, loneliness, and self-pity.

Or, **picture a person** who overcomes his own obstacles, to remain independent and a part of his family and community, surrounded by the love of his family and friends, helping to make them happy, too.

I know that you, too, are concerned, or you wouldn't have taken your time to be here today. Thank you again for this opportunity.

Senator PRYOR. Pearl Herman also is someone who is, as they say in the Department of Human Services, if I may use this phrase—they say, "I want Pearl on my side," because she is the Advocate today. She is the Advocate for every elderly person. She is the Advocate for every person who is dysfunctional. And she goes to bat many times against the bureaucracy and, I imagine, many times against your own office. And she is also not without honors. She has just received two wonderful honors in 1988 and 1989, and we just appreciate you being here and we look forward to your statement. If you would, bring the microphone a little closer.

STATEMENT OF MRS. PEARL HERMAN, ADVOCATE, ARKANSAS DEPARTMENT OF HUMAN SERVICES, LITTLE ROCK, AR

Mrs. HERMAN. Good morning, Senator Pryor, friends and advocates. My job title states that I am the DHS advocate. An advocate is one who speaks or resolves issues for others. However, many DHS agencies and employees consider me the DHS agitater, pest, and one who disrupts their day. Having served as Department of Human Services Advocate for almost 19 years, I've had a unique opportunity to watch the evolution of clients served by the various programs available for the elderly. And in that respect, to use an old cliché, I have some good news and some bad news.

When I first began working for the Department of Human Services, the typical client in need of assistance usually met the following criteria: First, they lived on a fixed income from Social Security, veteran's benefit, SSI, and so forth. Second, their monthly expenses were much greater than their income. Third, they were faced with choosing between medication, food, utilities, and in some cases, a place to live. What meager savings they had was utilized to pay off catastrophic emergency medical bills. They try to trust their children, relatives, and friends to keep their moneys or other financial situations, only to find themselves penniless and their property gone. Those trusting, God-fearing church people now find themselves having no trust or faith in anyone.

The bad news is the description of the typical client in 1972 is basically the same description of a typical client in 1990. Their income is still woefully insufficient to meet the growing cost of basic day-to-day necessities, not to mention the cost of prescription drugs and other medical expenses.

The programs and services available for the elderly today are innovative and provide the means of many individuals to live independently. However, the number of people needing these services far outweighs the dollars available to furnish them. How can we stretch an already straining budget to serve the growing number of older citizens? Right now, there are 30 million people in the United States over age 65, and 8.4 million of those live alone. By the year 2030, there will be 30 million elderly citizens living alone in the United States, and that's more that the entire population of Canada. This startling statistic should make all of us aware that we cannot stand still and simply maintain the status quo in providing and planning for the requirements of the 65-plus population.

To those of you who are in a position to utilize the moneys we have available to date for services to the elderly—use that money wisely. Be a fighter and an advocate for your clients.

Now, the good news is we are fortunate to have our Senator David Pryor as the leading advocate for the elderly in the United States and we also have, in my opinion, a trained professional and caring staff in our Division of Aging and Adult Services and Area Agencies on Aging who work diligently in providing an impressive range of services geared especially for older Arkansans. However, many employees are frustrated, stressed out, overworked, and underpaid as they attempt to serve—especially the workers in our rural communities.

I recently received correspondence from two different aging network employees who work in rural areas. An employee from the Southeast Arkansas Area Agency on Aging writes that she serves a 10-county area. She says the elderly are very poor because they spent years working in cotton fields making money for someone else. Farm labor was not covered by Social Security, and the majority are only eligible for SSI. Through no fault of their own, they did not have the opportunity to obtain an education. These people are competely dependent on outside help. They are sitting ducks for exploitation and abuse. Some problems she said that she encountered are: transportation; no taxi or bus service. If friends or relatives transport them, they are charged an outrageous fee. Home-delivered meals; no meals delivered beyond the county line. Substandard housing. Medical services; clients may be eligible for Medicaid. But because an aide is not paid for mileage and works for minimum wages, they are often unable to furnish this service.

As we've seen on the film, some areas have no doctors. Some areas have no senior center which provides a noon meal, socialization, and advocacy. Illiteracy; skyrocketing prescription drug costs, it is difficult or impossible to buy medicine which is necessary, such as heart medicine, blood pressure, oxygen, insulin. Even people eligible for Medicaid are affected due to cuts in Medicaid. Unable to pay the doctor; no pay/no service. These people are helpless under the present system. Protective services; even though there is a law in Arkansas regarding abuse and exploitation of the elderly, often some prosecuting attorneys show no interest in prosecuting the perpetrator, so why have the law?

This individual worked for Social Security for 30 years which served nine counties in southeast Arkansas. She knew it was a poor area. She states that however, not until I worked as a social worker for this agency did she realize how bad it is. "I have been in this field 11 years. If I had not observed the situations I have, no one could have made me believe them."

"If the committee members who make the law," she further states," could personally observe the problems of the elderly, maybe then they would open their eyes and hearts. If you have not been there, you cannot feel the full impact. They need to realize that our poor elderly are not living; they are only existing." She says further, "I hope this information is informational. And if we only had more people in power like Senator David Pryor. He really does care."

Another area, and I'll just summarize this, from northwest Arkansas, they stressed on transportation. And this writer says, "While there is adequate transportation for senior citizens for those able to ride the bus, it is limited to only certain days and hours." Clients have limited visits per month to areas that would give comparison prices on food and drugs and so forth.

The agency does well with very limited funding; however, in rural areas, the funding is not adequate to cover the distances needed. Medicaid is limited to one doctor's visit per month, and this does not include time or provisions for paying bills, shopping, or any extra needed trips. Clients that do have Medicaid, or even if they don't, have no regular access to physicians. Many are hard-pressed to obtain medical care due to lack of family, volunteers, lack of clerical support and public transportation.

For example, if a client wakes up ill in the morning with a serious problem, one that local transportation could handle instead of an ambulance, there is no support system. What do they do?

In the rural counties, there is often inadequate apartments or houses for rent for the low-income elderly. If there are these type of facilities, there is always a waiting list. Sad to say, someone has to move or die to provide a vacancy.

Nutrition; our senior citizens do an excellent job with limited funding. There are some concerns that perhaps might be addressed. We realize we cannot provide a special diet or gourmet foods for every person. However, to help follow adequate health care from prescribed diets by doctors, it would be of help if, in basic preparation of meals, that they would eliminate sodium. However, we are often unable to meet the requirements of those with specialized diets because of budget limitations.

Better nutrition with quality foods enables clients to be more alert, more resistant to disease, and have less need for hospitalization. Most have limited funds left over each month after paying necessary bills and buying adequate medication, saving for taxes; therefore, little is left to buy quality foods. Physical abuse—physical abuse does occur in varied forms. Neglect by family members of physical and emotional needs, verbal abuse, and threats.

I am going to skip and go over into prescription drugs. It is sad that clients with serious medical problems that require multiple medications must, due to costs, try to use the one that perhaps will make them feel bettter, for example, less pain and neglect and perhaps one that is more beneficial to their life. Another example, they will neglect medication for hypertension to take medication to relieve a painful kidney infection, and at the same time, not use a much needed heart patch to be able to buy their ulcer medicine. What price do they pay by doing without doctor-ordered medications? The results are frequently hospitalization, more trips to the physician, and earlier institutionalization.

These are just a sampling of issues that our beautiful older Arkansans face today in rural Arkansas. Other major concerns are our adults ages 18 to 60 who are floating from agency to agency needing services and are pushed aside in many counties because they do not fit certain criteria. And to address our mentally ill elderly, Senator, would take another full day's hearing. In spite of our many problems, frustrations, and daily sad experiences, our

aging network is here to stay and will continue to provide the best for a deserving group of people, our older Americans. Thank you.

Senator PRYOR. Thank you very much, Mrs. Herman.

That was a very eloquent statement. I'll have a couple of questions for each of our previous witnesses in a moment. But next, our third member of the panel is Dr. Steven Collier, the Medical Director of the White River Rural Health Center in Augusta, AR. Dr. Collier, thank you for being with us today.

STATEMENT OF STEVEN COLLIER, M.D., MEDICAL DIRECTOR, WHITE RIVER RURAL HEALTH CENTER, AUGUSTA, AR

Dr. COLLIER. Thank you, Senator Pryor, other distinguished guests, I appreciate the opportunity to express my views concerning long-term care in rural America. It's encouraging to me that there is growing recognition of this need, and my testimony today will relate to the problems that I encounter each day in my practice in rural Arkansas, particularly in the area where over 20 percent of my patients are elderly patients.

I've been in rural practice for 9 years. I've been working for a community health center. In a community health center, the mission is to provide comprehensive primary health care to all residents of a service area, and in recent years, we have stressed health, education, and preventative activities.

Community health centers are located primarily in eastern Arkansas where we experience a population that has over 20 percent age 65 and older. It's my opinion that community health centers of Arkansas stand ready to provide a program of community—of comprehensive health services to a growing geriatric population in Arkansas and in America. I will address some of the services provided and explain how they can help the long-term problems overall and be very specific in some of the programs that we have available in our system and some of the programs that are available statewide through the community health centers.

My first point is prescription drugs. In our area, we are faced with two very distinct problems. One is the section of the population that, when receiving primary care, cannot afford to purchase the required medication at their local pharmacy, and that's a very real problem that I deal with daily and have two mechanisms in my practice to take care of that, as I am a strong sampler, and some of the drug companies have been charitable enough to participate with us in sampling. And so that's a help to our patients, but that's just not enough to go around and that's episodic.

There's a large segment of our population that's outside of the Medicaid Program. And community health centers have addressed this problem and I'm proud of this. They've addressed this in providing a house pharmacy or contracts with our local pharmacies in assuring that all patients receive the proper medication. And we have received a grant that the funds are applied toward patients' pharmacy bills in these particular situations when the patients are unable to afford them, and this program has been very successful. There's some community health centers that actually have an in-house pharmacy. In my particular system, we do not have a pharmacy but do have the contract. I feel like that this program needs

to be explored further because it's been very successful in our area. This program should be expanded for the elderly. It's my belief that this would prevent many elderly from developing into long-term nursing home patients also with the proper medication.

The second problem that I see in my daily practice—and I really see this primarily in nursing homes; I'm the medical director of a 120-bed nursing home in McCrory, AR—is the practice of polypharmacy. And I've declared a personal war against polypharmacy. And polypharmacy is the use of multiple drugs, usually greater than seven, in a situation where without reviewing medications, sometimes patients, doctors, and physicians don't realize what amount of drugs that a patient is taking.

Our elderly often are exposed to more untoward side effects of these drugs because of this practice. Review of all medications taken should be a priority for all of those involved in long-term health care. Reduction of polypharmacy would be of great medical and economic benefit to this country. In my practice, I feel that it's had a very positive result in the form of more alert patients and decreased drug bills.

The second point is home health care. In my practice, home health care has been a very integral role in caring for the elderly. The home health nurse has become the eyes and ears of the physician in the clinic. The home health nurse becomes very involved in the patient's well-being. The nurses really take a personal interest in their patients. Professional nurses in the home are able to make assessments of the patient's nutrition, housing, and the ability to function in his environment, as you noticed in the film. It makes a difference if you're able to go in someone's home.

In the area where I practice, over 50 percent of our population is without a high school education, and I'll follow up on this later of how we've tried to integrate that into our practice. I feel the home health agencies deserve our respect as a solution to long-term care problems facing us in America. I'd like to make that as my second point.

The third point which will be covered later is transportation. The way I see it, transportation is an obstacle to obtaining health care services. Many community health centers have transportation services that involve vans and volunteer workers. The problem that we deal with in a rural county—as I noticed on the film, they were talking a matter of 17 miles. We have one particular clinic in Cotton Plant that's 60 miles from a hospital. Just yesterday, I had to transfer a patient from Cotton Plant to Searcy. So you're talking long distances. And we are fortunate enough to have a paramedic ambulance service, so this has brought a certain level of technology to rural Arkansas, and I think that funds for emergency transportation need to be explored.

My fourth point is physician recruitment. In rural Arkansas, I encounter great difficulty in recruiting physicians to locate in our region. There have been several contract negotiations that I've been involved in. And so often, they get down to the final stages and find that the physician is taking my package and comparing it to what he can make here in Little Rock or an urban area, and he's just confronted with that economic reality. And they find out that it's more advantageous either to specialize or to practice in an

urban setting. And for several reasons, most of those are economics. But the rural physician has been underpaid when compared to their urban counterparts. The Resource Base Relative Value System is intended to rectify some of the inequity in our present system, and I am hopeful that this will have an effect.

The fifth thing, to close, is health education. Community health centers are committed to health education as a deterrent to illness. Many of my elderly patients have expressed an interest in educational opportunities such as seminars such as this and educational courses and books.

In summary, I would like for you to know that community health centers stand ready to assist with whatever comprehensive program that is developed, and we appreciate your support. Thank you.

Senator PRYOR. Dr. Collier, thank you very, very much.

[The prepared statement of Dr. Collier follows:]

STEVEN F. COLLIER, M.D.

TESTIMONY PRESENTED TO:

SENATE SPECIAL COMMITTEE ON AGING

"LONG-TERM CARE IN THE 90'S - SPOTLIGHT ON RURAL AMERICA"

AUGUST 21, 1990

GILBREATH CONFERENCE CENTER

BAPTIST MEDICAL CENTER

LITTLE ROCK, ARKANSAS

Senator Pryor and other distinguished guests, I appreciate the opportunity to express my views concerning long-term care in rural America. It is encouraging to me that there is a growing recognition and need to take a comprehensive view of long-term care, as it relates to rural America.

Since 1981, I have been a staff physician, and I am currently Medical Director of White River Rural Health Center, Inc. in Augusta, which is a Community Health Center, providing primary care to all residents. I also serve as Medical Director of Woodruff County Nursing Home, a 120 bed skilled care nursing home, along with being Medical Director of Nurse, Inc., a home health agency in Woodruff County, and Medical Director of Central Paramedic Services.

My testimony today will relate to the problems I encounter each day in my practice of medicine in rural Arkansas, particularly in an area where over twenty-five percent of my patients are elderly.

The mission of Community Health Centers is to provide comprehensive primary care to all residents of a service area and in recent years we have stressed health education and prevention activities. Community Health Centers in Arkansas are located in the Eastern part of the State, where we experience a population with over twenty percent age 65 or over and a minority population in excess of thirty-five percent, which well over half of those are elderly.

It is my opinion that the National Association of Community Health Centers and Community Health Centers of Arkansas stand ready to provide a program of comprehensive health services to a growing geriatric population in America. I will address some of the services provided and explain how they can help the long term care problems overall.

1. PRESCRIPTION DRUGS: In this area, we are faced with two very distinct problems. One is a section of the population that when receiving primary care cannot afford to purchase the required medication, at a local pharmacy. This is a large segment of the population outside of the Medicaid Program. Community Health Centers have addressed this need in providing a house pharmacy or contracts with local pharmacies in assuring that all patients receive proper medication. This program should be expanded for the elderly, this would prevent many elderly developing into long term care nursing home patients.

   The second problem concerning medication is the practice of polypharmacy. Polypharmacy is the use of multiple drugs, usually greater than seven. Our elderly population are often exposed to more untoward side effects of drugs, because of this practice. Review of all medications taken should be a priority for those involved in the long term care. Reduction of polypharmacy would be of great medical and economic benefit to this country. In my practice, I feel that it has had very positive results in the form of more alert patients and decreased drug bills.

2. HOME HEALTH: In my practice, home health has become a very integral role in caring for the elderly. The Home Health Nurse has become the eyes and ears of the physician. The home health nurse becomes very involved in the patients well being. Professional nurses in the home are able to make assessments of the patients concerning housing, nutrition, and the ability of the patient to function in his environment. In the area where I practice, over fifty percent of our population have less than a high school education. I feel the home health agencies deserve our respect as a solution to long term care problems facing us today.

3. TRANSPORTATION: To many elderly, transportation is an obstacle in obtaining health care services. Many community health centers have a transportation service available to these patients. Transportation should be available in rural areas, not only to transport patients to local clinics, but also a means to get patients to an appropriate specialist, if so indicated. With the closing of many rural hospitals, many elderly are 50 to 60 miles away from a hospital or specialty medicine. Paramedic ambulance service to rural areas has been a lifesaver to many elderly.

Financing of transportation services in rural areas calls for a cooperative effort between federal, state, county and city governments.

4. PHYSICIAN RECRUITMENT: In rural Arkansas there has been great difficulty in recruiting physicians to locate in this region and provide health care to the elderly. On many occasions potential candidates like the idea of practicing in a rural setting. When the physician is confronted with the economic reality, they find it is more advantageous to specialize and practice in an urban setting. Rural family physicians have been underpaid when compared to their urban counterparts. The RBRVS resource base relative value scale is intended to rectify some of the inequity in our present system. Primary care physicians are needed to provide the basic medical services to the elderly in rural America. I would encourage incentive pay for locating in a rural area.

5. HEALTH EDUCATION: A deterrent to long term care may be in health education and prevention activities. Many of my elderly patients express an interest in educational opportunities. There is much support in my practice for literature concerning aging. This could be accomplished through books, tapes and television. Educational institutions should be encouraged to offer workshops seminar and courses with the elderly in focus. From my viewpoint education can provide the patient with a much better understanding of their health.

In summary, we must realize that during the geriatric life cycle, there is greater likelihood of multiple, chronic and often disabling health problems. It should be our goal to relieve as much suffering as possible. More specifically our goal should be to provide treatment and follow-up of geriatric patients with hypertension, diabetes, cancer, heart disease, and arthritis. In order for us to be effective proper medication must be provided, home health care must be available transportation is necessary, physicians must be accessible and health education must be stresses.

Senator Pryor it has been my pleasure to bring these concerns to your Committee.

Senator PRYOR. I can tell you, Dr. Collier, knowing of your reputation and especially those in the communities that you serve, those people appreciate you. And I wish there were a lot of Dr. Colliers all over this country that would make the sacrifices you do. We applaud you and we thank you.

Dr. Elders, you made a statement awhile ago that is awesome to me. I'd like for you to restate the area. It was in the last part of your statement where we have a $600 billion program, and what percent of it, tell me that again, goes to the last 30 days of——

Dr. ELDERS. Senator, our health care budget is $660 billion. That's what the Federal Government spends, private insurance, you know, that's what we, as individuals, spend on health care. Out of that—that's 12 percent of the gross national product of the United States. Out of that, Senator, 90 percent, 90 percent, is spent on the last month of life. Only 0.8 percent of it is spent on preventative health services. And so we really are not promoting wellness for our people. Most of that is really spent in intensive care units and, you know, for things that really do not improve the quality of life for our citizens.

Senator PRYOR. That is an awesome figure, and I was not aware of that figure. And I'm learning something, I want you to know, here this morning. I'm concerned about—and I see that issue of Alzheimer's disease. It seems like just in the last 5 years, Alzheimer's—or the last 10 years maybe, that now we're dealing—is this a new disease? And if so, what are we doing, not only in the area of Alzheimer's in specific instances, but you mentioned the caregiver. I find in many Alzheimer's cases that the caregiver is mentally, physically, financially exhausted. I wonder if you might just—you or Mrs. Herman, either one, or Dr. Collier.

Dr. ELDERS. Senator, it's sad that, you know, 5 percent of our elderly population do really have Alzheimer's. We don't know—I do not think it's probably a new disease. I think it's probably a newly recognized disease or entity. And, we were aware for years, that as we get older, our memory goes and a few things go, and now we have a name for it.

But certainly I think that we need to provide some support for the caregivers. Even if it's just a day out or a weekend out, and certainly we know that sometimes this is literally impossible. And our system does not allow family members to be reimbursed for providing this care, and we know that family members provide more of the care in their home for our elderly and for certainly our patients with Alzheimer's than in any other way. And I feel that we need to re-look at that system. And the other thing is we know that for going to nursing homes, if our people make something like less than $400 a month, they're not eligible for Medicaid. But they can get up to $1,100 or $1,200 a month and still be eligible for nursing homes. I think we really need to look, re-look at the eligibility and make it the same for both nursing homes and for the families who really take care of their loved ones in their own home.

Senator PRYOR. Well, I don't have this exact figure with me, but I've been told that I think it's by the year 2010, that's not a long way off, or 2008 maybe, that the average nursing home stay is going to be around $35,000 a year, and I'll bet it's going to be a lot more than that because of the skyrocketing health costs.

Mrs. Herman, you look like you might want to add in on one of those answers there. Did you want to add anything, or Dr. Collier?

Mrs. HERMAN. The comment that—I guess that always bothers me, Senator, when I hear from family and friends, we don't often plan early on. I just walked through this same experience, I told Portia. I just placed my 90-year-old mom just 2 weeks ago into a nursing home here. And the other piece of that, her brother had lived with her over 50 years. Then we had to place Momma, who now has Alzheimer's. And the day we placed her, someone had kicked in the door in their home. So it's dealing with the crime, having to go through that, replacing, and it was exactly 1 year ago that my mother-in-law passed in a nursing home. And both of these beautiful individuals, we, as caregivers—I'm guilty, we do not plan early on. So I urge you to take a look. Take a look at your own long-range goals. Do this for your parents. You advocates out there, let's not wait. The Office on Aging has a good network of folks and a lot of excellent resources, and I know that there is an Alzheimer's Society. So please call on them. They have good information.

Senator PRYOR. Thank you. Dr. Collier, did you want to add?

Dr. COLLIER. The thing about Alzheimer's specifically—and I had mentioned polypharmacy. And a lot of times in certain situations, people are inappropriately treated for Alzheimer's with antipsychotic medications. And we have some regulations that are going into effect, and I've already been screening my patients for this problem and it seems to be helping. Tying a patient's mind up is not a good thing for Alzheimer's patients.

Senator PRYOR. What about the situation on the prescription drug issue? I can certainly ask this to any of you, but I'll start with Dr. Collier. When that elderly patient, say a Medicaid recipient, the doctor has prescribed, say, six drugs and they can only afford four or three, who makes that decision as to what drugs they do not take? Does that individual make that decision? Tell me what's the lay of the land out there in this issue right now.

Dr. COLLIER. From the medical standpoint, I adhere to the point that it's prescribed when they need it. Oftentimes what will happen is, they will take the prescriptions home and just not get them filled. I've even been in the grocery store and even at the pharmacy, and they will just hand the pharmacist the prescriptions for some of them to be filled. The ones that are the cheaper medications are usually filled. And that's the way it really is in the real world. And I don't like that, but that's what I see in my practice. And I sometimes just try to ask them, I say, "Now, if you can't afford it, well, tell me and we'll try to make some arrangements." But a lot of times, a lot of people have a certain amount of pride and they're not going to tell you, "Well, Doc, I can't afford this expensive heart medicine." They'll take it and either just put it in their pocket or not get it filled.

Senator PRYOR. Now, we see Medicaid programs—not only in Arkansas, but in all of the 50 States, we see some of the services of the Medicaid programs being cut back, cut back drastically. And to a large extent, we see one program that doesn't seem to be cut back, and that's the huge profits that drug manufacturers are making, and so we're giving more to the manufacturers. And because we're giving so much to them, we're having to cut back other

services. Are we having to cut back some of the Medicaid services today in our State? And if so, are they programs that directly affect the elderly?

Mrs. HERMAN. Senator Pryor, I'm fortunate to have an excellent support system, and I see Kenny Whitlock standing in the back. And when Portia called me, I said, "These are the policy issues that I know that we're working on," Dr. Yamuchi, Kenny, and others on the staff. And if Kenny would like to address these issues, the mike is yours.

Senator PRYOR. I tell you what I might do. After this panel and the two succeeding panels complete, we may ask for Kenny to come forward to the mike and make a statement on this issue, and I think that would be the appropriate place to do it.

We saw down in Stephens, AR, those very, very sad cases. That's, by the way, my home county, Ouachita County, the southern end of the county. And I recognized some of those little roads and byways there in the very moving picture. If we had the money, if we had the resources, to plow into the home delivery services, let's say if we had the money, do we have the infrastructure out there to do it? Do we have the number of people who would be willing to drive 40 and 50 and 60 miles a day delivering those meals to those people? Do we have the people to go with the dollars into making these deliveries and performing these services?

Mrs. HERMAN. Senator, in my opinion, some areas of the State have a better networking system already built in. But I think that we, in Arkansas—we have the capabilities, and we've got a system working jointly. And I think in those areas where we're hurting, we need to ensure that the entire community—the retired individuals, the church people, I think we've got it. I think we could do an excellent job with pulling that together.

Dr. ELDERS. I would support that, Senator. You know, we, at the Health Department with our in-home services, we are providing many kinds of in-home services, we are providing many kinds of in-home services that I had mentioned to you, things like, just personal care, housekeeping, and many of those services. And I think we may not have the infrastructure in place. But the reason we do not have the infrastructure in place all over our State is simply because of the lack of reimbursement systems for these services.

I can assure you, if we had the reimbursement system in place for long-term care for our elderly, that our private entrepreneurs, we at the Health Department, or wherever, I feel that we would develop the infrastructure. It's sad, but we know that health care in America is directly related to dollars.

Senator PRYOR. I was asked to speak this past Sunday morning at a local church in Little Rock, and they wanted me to talk about the subject of growing old in America. It seems like that's all I talk about lately is growing old, but anyway. And I mentioned in my remarks, just informal remarks, that after about 30 years of being involved on the local and State and national level in the field of government and public service, politics, whatever, I've now become convinced, I think, that government can't do everything. I don't think we can do it all. And I think it's going to have to be churches. I think it's going to have to be organizations. And I think it's

going to have to be civic clubs. And I think it's going to have to be communities that really take up the slack.

I had a real rare experience some months ago to cut the ribbon in Rogers, AR, up in Benton County. This is called the GAC Clinic. It is the Geriatric Assessment Clinic. And it is a wonderful, a wonderful, very innovative concept. In addition to the clinic, and I think this is run by the Catholic Church, there is also an adult day care center. And early every morning, 5 days a week, you can see young couples bringing to the adult day care center, not their children to drop off while they go to work, but their mothers and dads and grandparents they drop off at the adult day care center. And it is run in conjunction with this.

And I think creative concepts like this are going to be the answer. And frankly I don't know. I think the government has failed. As a matter of fact, I think I have failed. I think all of us have failed in this effort. But we keep saying that, you know, if we could just give more money and more money, and that's certainly a critical key. But there's going to have to be down there—there's going to have to be a lot more Steve Collier's and Dr. Elders' and Mrs. Herman's philosophies out there, I think, embodied, not only in the programs, but also in those ultimate services that are rendered.

Well, ladies and gentleman, I think we will dismiss this panel. We want to thank you. And any additional comments you would like to make, you may supply them for the record. I thank all of you. Let's give this panel a hand.

Now we're going to have Mr. Charles McGrew, who is the Director of the Division of Health Facilities, Arkansas Department of Health. Mr. McGrew is certainly no stranger. Mr. Edward Haas, Contract Services Supervisor, White River Area Agency on Aging from Batesville. I believe Mr. Haas is on his way to the stand. And one additional witness that we were going to have has had to cancel; that is, Mr. Clarence Anderson, who is on dialysis and had some complications yesterday. But his spokesperson, Mr. James Loftis, is going to be present representing, I believe, Mr. Anderson. Thank you, James, for coming.

James, we were going to have Clarence on first today. And you as his spokesperson, would you like to stand in? And I am going to place the entirety of Mr. Anderson's statement that was prepared—I am going to put it in the record. Maybe you would like to talk about it a little bit.

STATEMENT OF JAMES LOFTIS, DIRECTOR, SERVICES AND OPPORTUNITIES FOR SENIORS, LITTLE ROCK, AR, SPOKESPERSON FOR CLARENCE ANDERSON

Mr. LOFTIS. Thank you, Senator Pryor.

Senator PRYOR. If you would, sort tell your relationship, please, to this whole situation. I think that might be helpful to you.

Mr. LOFTIS. In my capacity as Director of Services and Opportunities for Seniors, I had an opportunity to come in contact with Mr. Anderson. We have been transporting him, I guess, about 3 years now. He goes twice a week to take dialysis treatments. At one time, he was going three times a week, but his condition has improved

enough now to where he just goes twice a week. And I want to apologize for Mr. Anderson. He was very disappointed that he was unable to be here today. But unfortunately, sometimes the treatments that he takes, they take quite a bit out of him, and he was ill and unable to come.

In terms of what I'd like to say as far as being Mr. Anderson's spokesman, there are going to be a lot of people that are going to follow me on the panel that are going to talk about the problematic and the logistical issues involved with transporting elerly people. In as much as my words will not be as good as Mr. Anderson's own words, I'd just like to read his statement.

Senator PRYOR. Certainly. I read his statement last night. It's very moving. Thank you.

Mr. LOFTIS [reading]:

My name is Clarence Anderson. I am 75 years old and I live in North Little Rock, AR. I was born near Carlisle, and I have lived most of my life in Arkansas. I did live in California for a while.

When I was young, I worked as a farm worker, but I've also worked in an auto parts store, a tire shop, and hotel. I've done contruction work, too. There's not too many jobs I haven't had to make an honest dollar.

When I got older, I had to draw disability because I had arthritis and couldn't stay at work. I couldn't stand up all day. Then I got old enough to draw Social Security. Between Social Security and SSI, I now receive $397 a month. I pay $175 a month to rent the house that I live in, and my utilities bills run about $125 per month, but they are more in the winter months. That leaves me with $97 per month for groceries and other things I need, such as prescriptions that are not covered by Medicaid.

I have family spread out all over the country. I do have one brother that lives near me, but he has been helpless for 2 years, and I have lots of nieces that live in this area. I have two children that live in California, but I have not had any contact with them in 10 or 12 years.

I have been receiving dialysis because of my kidney disease since February of 1988. I have to get these dialysis treatments in order to live. At first, I went for dialysis treatments three times each week; now I go two times. I also have high blood pressure and rheumatoid arthritis.

There are a lot of people in pitiful shape that can't do for themselves. They don't have anyone to depend on to help them out. Sometimes it's rough with me. I don't have anyone to depend on to take me to my treatments or to get my prescriptions filled. It's hard to get some people, like people in the neighborhood, to help out. I have to pay them $5 each way to take me to the treatments, and sometimes they just don't come by to get me. They say they have other things they need to do or they just forget. They don't care about nothing.

Services & Opportunities for Seniors have been taking me for my treatments for about 4 years. I can set my clock on them to be by to pick me up. I know they will be by. They also take me to the drug store to get my prescriptions filled. I don't know what people would do without services like this.

I can't afford to get myself to the dialysis center for my treatments. Some people want $5 each way to take me, and I can't even rely on them coming by. I take two treatments per week. At $5 each way, that would cost me about $80 a month.

I have used a cab to go to my treatments, but they also cost about $5 each way. And I can't rely on the cab to be on time to get me to my treatments.

The city bus runs down the street near my house. I would have to make one transfer to get to the dialysis center at the hospital. It doesn't cost to much to ride the bus, but I would have to stand around and wait at the bus stops, which would be hard on me in the heat and standing at the stop, especially after my dialysis treatments which make me very weak.

The American Red Cross has a transportation service that could take me to my treatments. They charge $3.50 each way. With the number of times I go for treatment each month, that would cost me about $56 a month.

A Medicaid eligible transportation provider can get reimbursed 34 cents per mile for transportation. From my house in North Little Rock to the dialysis center at the hospital, it's 3 miles, six miles round trip. If I used a Medicaid transportation service provider, which is the cheapest alternative to what I'm doing now, they would be

reimbursed a total of $2.04 for the round trip to the dialysis center. That would leave $4.96 per round trip, or $40 per month, that would have to be made up some other way.

With the income I receive from Social Security and SSI each month, I can't afford to pay out of my pocket that much to get to the dialysis center.

The transportation services I receive from Services and Opportunity for Seniors helps me stay in my house. There's a grocery store about a half a block from my house and I can walk there for my groceries. I can do that myself, but I can't get to the dialysis center for treatments by myself. I can't get to the drug store to get my prescriptions filled. Without this service, I couldn't live in my house. I couldn't stay independent. I would have to go to some place to live where I could get my treatment because I can't live without them.

Thank you, Senator.

Senator PRYOR. Mr. Loftis, thank you very much. I wish he could have been here because our staff has interviewed Mr. Anderson and they said he is a very, very eloquent and convincing person. I'm sorry he couldn't be here. I think we are right now at exactly about the halfway mark in our hearing. What I am going to do is declare a 5-minute recess and then we will continue with this panel.

[Short break taken from 10:17 to 10:30 a.m.]

Senator PRYOR. Ladies and gentlemen, if we could continue, we will try to ask for a little quiet back in the back of the room until everyone gets resettled.

Our next witness is Charles McGrew, Director of the Division of Health Facilities from the Arkansas Department of Health. He's going to talk specifically about some of the transportation problems in rural Arkansas, which I know apply to rural America. And Charles, we appreciate you being here. You may proceed.

STATEMENT OF CHARLES McGREW, DIRECTOR, DIVISION OF HEALTH FACILITIES, ARKANSAS DEPARTMENT OF HEALTH, LITTLE ROCK, AR

Mr. MCGREW. Senator Pryor, members of the audience, as most of you know, the health care system in Arkansas, like most of rural America, is changing rapidly. Since 1980, we've had 11 hospitals close in the State. Those have been rural facilities. Right now in the Department of Health, we have requests from 34 counties to assist in recruiting a physician. A lot of those hospital closures have resulted because active physicians were not available in the community to continue to admit patients, or there were problems with nurses being available to that rural hospital.

Unfortunately, if a hospital closes, the physicians who remain in the community usually don't stay there very long. They're looking for places where they can admit their patients to a hospital, have laboratory backup, and have assistance from their colleagues and other services. So if a hospital closes in a rural community, it's not just the fact that you have a hospital closure, you also—in those situations that we're seeing in Arkansas and most of the country—lose physicians who are in the community.

Those folks in communities who have never had a hospital but have had a physician in town for a long period of time are not faring much better right now. What happens when physicians retire from small rural communities is that young physicians who are graduating from medical school and their residency programs

want to practice somewhere where they'll have a colleague or colleagues. Also they want to be where they won't be on call 7 days a week, 24 hours a day.

You've heard in the video this morning Troy Foreman from Stephens talk about the fact that they had a clinic there that had been vacant for a couple of years. It had been successful in the past in recruiting a young physician from that part of the State who practiced very successfully there for a period of time, but that physician simply was not able to keep up with that solo practice, and he burned out. He also was not able to make enough money because he wanted to see everyone who came to him. And over a period of time, he simply could not, in that setting, make a living. So that's one of the complicating factors that we have.

What this means to rural communities and to the over 65 population is that you're going to have to travel farther to get medical care, to see a physician, to be admitted to a hospital, to get those services from a hospital that they provide that are of a nonemergency nature. And we know that that trend is going to continue in the State unless something can be done to reverse hospital closures and what attracts physicians to rural communities.

Again, in his testimony, Dr. Steve Collier talked about the fact that a lot of physicians, because of economic issues, don't want to settle in small towns. Another factor that we look at there is the fact that families of those physicians have other priorities. It's a difficult problem to deal with. We've got to make progress in finding ways to get care back into those communities. But yet, in the short run, it means that you are going to be traveling farther to obtain that medical care.

According to the 1980 census, 28 percent of the U.S. population could be described as transportation disadvantaged. And I don't think in Arkansas in the last 10 years that situation has changed very much. Or if it has, it's changed in the wrong direction.

Last year, the Department of Health's Office of Primary Care held three regional seminars around the State to try to help communities that are interested in stabilizing their health care system to provide better health care services for their community. We had 20 counties that participated in those three seminars. And in every case, people from the counties that were represented there said that transportation to medical care was one of the major problems that their community faced. We hear that over and over.

What we are talking about is people like a 79-year-old man from Phillips County. This is a person that we're taking care of in our in-home services program. He is living alone. He has a major problem with arthritis, has a major problem with hypertension and being able to control that hypertension. He has no way to get to medical services. In addition to that, he does not have the ability to be able to just do routine shopping for groceries or for clothing or to take care of business or to do all of those things we just take for granted—I mean, just a daily ability to go about your life that transportation provides for all of us. In addition, if he can't pay someone to transport him, he may have to send money with someone to buy groceries to be able to remain in that situation. And in some cases, the groceries never get back to him and sometimes the money is not returned when he sends someone for groceries. Again,

we're talking about the kind of situation that exists all over the State of Arkansas, and we've all been touched by this in one way or another.

This is not an example of someone who died suddenly because of lack of transportation to medical care. But I think it may be every bit as important because what it does is over time, it shortens lives and it takes away the quality of life that those folks would have if they had the ability to live as we all want to live and as we expect to because we've got transportation to get to places that we want to go.

If you think this is an isolated example, last week in a quick telephone survey with some of our in-home services staff, we identified over 100 people, and these are individuals who had major problems accessing health care services because of lack of transportation.

These are other examples of individuals who have major problems in accessing health care due to a lack of transportation.

A 78-year-old female from the Snow Lake area, suffering from low blood pressure and arthritis, for example. She needs to see her doctor at least once a month but she is only able to see the physician once every 3 months due to a lack of transportation and her inability to pay someone to take her to the physician. She is on a fixed income and uses her money for medication and food.

A 93-year-old male, on a fixed income from Marshall, AR, is bedfast due to heart, bladder, and prostate problems. His wife is an amputee. They depend on the local ambulance to get to their physician's office. The wife stated "the lack of transportation has made it hard for them to get the basic necessities for their life."

An 87-year-old female who lives alone, on a fixed income, in El Dorado, AR. She broke her hip years ago and has been confined to a wheelchair ever since. She is dependent on her son who lives in Texas and her daughter who lives in Louisiana to take her to her doctor appointments. She stated "that if they couldn't take me to see my doctor I would have to call an ambulance and that is expensive."

A 64-year-old female dialysis patient living in Malvern, AR, has to travel 36 miles round trip to Hot Springs three times per week for her treatments. She stated "Medicaid pays for my transportation but there have been times when I would have to find someone to take me to the doctor. I have to pay them out of my own pocket, which means that I am short of money for that month."

A 78-year-old female, living in Fordyce, AR, suffers from arthritis. Currently she has her own transportation but she stated "there are times when I am in so much pain that I can't drive myself to the doctor's office or to the drug store to get my medication so I go without it until I am able to drive." She also stated that "last week I was so sick that I needed to go to the hospital, but I had no way to get there. I called the local health unit and they were able to take me to the hospital. If they couldn't have taken me, I don't know how I would have gotten there."

What we need is not just a transportation network that will get people to medical care. We need to be able to build on the infrastructure, in some cases, that is already out there. We've got a lot of rural transportation providers.

One of the other panel members has done an outstanding job with an Area Agency on Aging. But there is not enough coordination between those people that fund transportation. There's not enough money to fund rural transportation statewide. And Senator Pryor, one of the things that you mentioned earlier I think is of critical importance, we've got to use volunteers and we've got to use the community if we're going to have successful transportation systems over time.

We just funded, with a dollar-for-dollar match, in Montgomery County a rural transportation provider, and they're going to be using volunteers to provide those transportation services. Those are the kinds of services and systems I think that can survive over time because the community raised an equal amount of money to be able to get that grant funding. They have volunteers who have shown that they're going to stay around and be providing services over a long period of time, and I think we'll see success there. But we've got to do also a better job with funding both at the State level and at the Federal level for that infrastructure for transportation. We need a little bit more money to get some things started.

I know Kenny Whitlock—who you, it sounds like, will be hearing from a little bit later in the hearing—is extremely interested in what Medicaid can do to provide better transportation services. He has a major problem with the Medicaid budget right now. But again, we've got to be innovative and we've got to make better use of community use and volunteers if we are going to see a system that will allow us all to live the way that we would like to because we have transportation to all of those things that we need, not just health care. And we also, I know, would like to see, many of you, your grandchildren and children, have access to educational opportunities, to jobs, to training, and those things that you don't have in rural Arkansas right now, in many cases because of lack of transportation. We've got to make progress if we're going to see the State move in the direction that we'd all like to see it move.

Senator PRYOR. Charles, thank you very much. As we all know, this is a panel on transportation. And we've heard, of course, from Mr. Loftis, who is representing an individual who could not afford transportation for his dialysis treatments. We've heard from Mr. McGrew, who has given us an overview of some of the transportation problems as they specifically pinpoint or find themselves increasing in rural America. And now we're going to hear from Mr. Ed Haas from Batesville of the White River Area Agency on Aging. And Ed Haas is actually out there in the field trying to provide transportation on a day-by-day basis. Ed, we appreciate you being here and we'd appreciate your comments.

STATEMENT OF EDWARD HAAS, CONTRACT SERVICES SUPERVISOR, WHITE RIVER AREA AGENCY ON AGING, BATESVILLE, AR

Mr. HAAS. I appreciate your invitation and I appreciate you using the word "Ed." "Edward," I didn't know who they had invited. I thought it was somebody else, but I appreciate the word "Ed," because that's what I'm used to going by.

Senator Pryor and the Senate Special Committee on Aging, for the past 12 years, I have served as the Contract Services Supervi-

sor for the White River Area Agency on Aging, Inc., in Batesville, AR. In this position, I have worked in the management of the Senior Center program that provides transportation, congregate, and home-delivered meals, chore services, and recreational opportunities to the 60-plus elderly in our 10-county area. I am currently serving as President of the Arkansas Transit Association, an association of transportation providers in the State of Arkansas, and I am currently serving as Chairman of the Transportation Committee of the Arkansas Association of Area Agencies on Aging. However, my keen interest in transportation does not come from those agencies. I have a common bond with my father. For over 42 years, my father has served as Supervisor of Maintenance, Southern Division of the New Jersey Transit System. Several years ago, I saw the need for a better bus and van driver training program, so I developed, with the assistance of the Arkansas Highway and Transportation Department, a bus-van driver certification program that is used statewide today.

If you were to ask an older person in the State of Arkansas to list some of their problems in living in a rural State, somewhere at the top of that list would be the word "transportation." In various need surveys conducted by the White River Area Agency on Aging, an overwhelming majority of older persons have identified transportation as their number one need. The old saying that "You can't get there from here," is actually true in Arkansas. The doctor may be 30 miles away. The bank may be 20 miles away. The store and pharmacy may be 15 miles away, and it's not unusual for the hospital to be 30 to 40 miles away.

Even worse, specialized care in Arkansas, such as kidney dialysis, is usually even further away at regional health centers. At the White River Area Agency on Aging, Inc., in Batesville, we receive daily requests for transportation to Little Rock and to Searcy to the CARTI.

If you own a vehicle and can afford to operate it, and if you have the physical capabilities to operate a vehicle, these obstacles are easily overcome. However, let's say that you are an average rider of an Arkansas Aging transportation bus in the State of Arkansas, put yourself in this position. You are now at least 75 years old. You are female. You live alone. You have some physical limitations. And your average monthly income is less than $400. You want to remain independent, but you can't afford to operate a vehicle and the kids have begged you not to drive because of your limited eyesight. The inconvenience it's caused and the hassle it's caused to someone else to take you somewhere is insurmountable many times. Many older persons in the State of Arkansas go through this situation every day, or they would have to give up their independence if it weren't for the Aging program buses. Under the Older Americans Act, transportation is an access service. In order to obtain other services, such as health care that we're talking about here today, transportation to these services is tremendously important.

Currently, the Arkansas aging network is operating 340 vehicles on a statewide basis to serve the transportation needs of those persons 60 years of age and older. In 1989, the aging network fleet provided 1.5 million trip rides for some 16,300 older Arkansans. Over

three-quarters of these individuals are low income and over two-thirds of the riders are female. In an inventory survey conducted in January 1990 by the Arkansas Association of Area Agencies on Aging, 115 of these vehicles either had 100-plus miles—or 100,000 plus miles or were rated in poor condition. An average per year travel of 30,000 miles, the Arkansas aging network can expect to have to replace one-third of the fleet each year to maintain an adequate and safe transportation system. The cost for replacing one-third of the fleet, a mere $2.2 million. These are not fancy vehicles, but standard 15-passenger vans that do pose some loading problems for older persons with physical limitations. The cost for a standard 15-passenger van in today's market is $18,000. The annual operation cost of 340 vehicles, which includes gas, oil, maintenance, and drivers' salaries, is approximately $4.7 million. The total cost of operating the Aging program fleet in the State of Arkansas is approximately $7 million. The cost of operating a transportation program alone almost equals Arkansas' total allocation of Older Americans Act funds for transportation, congregate meals, home-delivered meals, chore services, and socialization. That total allocation is $7.8 million.

The latest population figures for the State of Arkansas indicate that the 60-plus population is approximately 462,000 people. In my opinion, the demand has already exceeded the financial resources. And if the population projections are correct, the demand for transportation among the elderly will more than double by the year 2010.

Those of us who work on behalf of the elderly can be proud of the accomplishments that we have made. However, with the projected aging of our population, our biggest challenge lies ahead. We will—how will we cope with the increased demand on the transportation system with the same amount of funding year after year? Increases have been far and few between, and with what little increases we have had, they have little effect on the operating of the transportation program.

In the reauthorization of the Older Americans Act, how do we do a better job at addressing the needs of the elderly? In appropriating more funds, Congress must realize an increased investment in our elderly is also an investment in all age groups as we develop coordinated mass transit systems. In light of the Federal deficit, I also feel that the elderly must be willing to share an even greater percentage of the cost of all services. The Older Americans Act should begin to address a charge for services rather than the current donation system. Our government and the consumer of services will be willing to share in the increased cost if we are to meet the demand in the years to come.

Finally, we must not forget how valuable the transportation system is to older persons who depend on the senior citizens bus every day. It is their link to the community that enables them to remain independent and it continues to enhance their quality of life. The figures I have just presented to you indicate that it costs approximately $430 a year, or $1.70 per day, to transport one older person to needed service. On June 28, 1990, my grandmother reached her 90th birthday. She belongs to a generation that taught us that an ounce of prevention is worth a pound of cure. I hope we

are listening. Thank you for the opportunity to address the reauthorization of the Older Americans Act.

Senator PRYOR. Thank you very much.

Jim, I wish—if you would, I know you are affiliated with an organization called SOS, and I believe that's Services and Opportunities for Seniors. Now, tell us about SOS.

Mr. LOFTIS. Okay. We are a service provider under Title III of the Older Americans Act and also the Social Service Block Grant program. We operate 13 senior citizens centers in Little Rock and North Little Rock. We have the—I think probably the vans that Ed was talking about as being the aging part of the fleet, I think we have every one of those. We also do the chore service program in all of Little Rock and North Little Rock. Of course, we operate the Meals on Wheels Program, too.

Senator PRYOR. All right. Now, why don't we—do you furnish transportation?

Mr. LOFTIS. Yes, sir.

Senator PRYOR. Why do we have SOS just in the very limited area of central Arkansas? Why don't we have it in 75 counties?

Mr. LOFTIS. Well, basically what we do, we have a network of service providers that are providing in those 75 counties. In Ed's——

Mr. HAAS. He is going to stick it on me in just a minute.

Mr. LOFTIS. The way that the network is set up, the area agency's contract is with the service providers to see that the transportation service gets out.

Senator PRYOR. Does SOS, for example, Mr. Clarence Anderson that you're filling in for—does SOS take him now for his dialysis treatment?

Mr. LOFTIS. Twice a week.

Senator PRYOR. Twice a week?

Mr. LOFTIS. Yes, sir.

Senator PRYOR. And does Mr. Anderson pay a fee for this?

Mr. LOFTIS. No. We are not allowed to charge a fee. All of our clients receive services free of charge, except we do ask them to make a donation toward the cost of operating the program.

Senator PRYOR. I understand. Did you want to join in?

Mr. HAAS. Yes. Senator Pryor, typcially what happens is, in each of the 75 counties, there is a service provider operating under the aging program. That provider normally provides transportation, congregate meals, home-delivered meals, and most of the time, most of those counties probably have two or three buses per county. The problem that you get into in developing specialized care or specialized transportation is, we operate, or the system is typically used to operating, over a fixed route system. I mean, that's the only way you can serve the people mentioned. That's the only way you can serve the majority of the county is if you designate a particular day for a particular part of the county when you're only operating two or three vehicles.

And when you get to doing specialized care, Jim is fortunate in the fact that the dialysis is right here in Little Rock. In our situation, the dialysis is in Searcy, and we don't—we have developed a specialized transportation system in cooperation with the CARTI,

and they are picking up some of the cost to help us get people down to Searcy to the CARTI.

Senator PRYOR. Okay. Here's a question, then, that I should know the answer to and I do not. What sort of surplus equipment do you have access to? Let's say Federal surplus equipment, military equipment, for example, do you get priority in purchasing this?

Mr. HAAS. Yes, we belong to the organization where you get the surplus equipment. But I don't know if we want to be putting that type of equipment on the road, to be honest about it. What equipment we have seen in the surplus property area is pretty well used, and we already have enough of those ourselves, to be honest about it. Anyway, so I'm not sure that that is a valuable resource in terms of operating a transportation system.

Senator PRYOR. I think we have a lot of M–1 tanks that are available. I don't know if you need any of that. Half of them have gone to Saudi Arabia.

Mr. HAAS. Well, I tell you this, they look better than the vehicles I've seen in surplus property.

Senator PRYOR. It seems like we spend such an unbelievable amount of money for all of this military equipment, and it looks like there would be something for use out there, for constructive use.

Mr. HAAS. There really isn't. When we—I mean, I've been out there several times, in the main surplus property place that's here in North Little Rock and Rebsamen Road. And when you go out there, the vehicles that are out there, generally you're fortunate if it has a motor in it. But, you know—so they're not the type of vehicles that—and if you did, we did have some experience in rehabilitating vehicles. And back several years ago when we got a little bit of additional funding, we rehabilitated about five vehicles. Well, they didn't last very long. Actually, you can sink $2,000 or $3,000 or $4,000 into a vehicle and you might get another 50,000 miles out of it. So, you know, it generally is not—the cost-benefit ratio is generally not as good as you might believe.

Senator PRYOR. Mr. McGrew, did you want to enter into this in any way? Are you involved in trying to explore here how we might be a little more creative in buying some more surplus equipment at a lesser charge? Are you involved in that particular program in the Health Department?

Mr. MCGREW. We're trying to work with everyone who is involved in transportation in the State to see if there are ways, and I know that they have been really creative to find ways to maximize the funding that they have and see if there are ways that we could use money maybe more efficiently. Again, what I mentioned earlier, some of the Federal funding sources have some requirements that are unique to their particular program, and we need to continue to look at that so that rural transportation providers that have several funding streams don't get caught in the bureaucracy. And that's an area I'm particularly interested in, as well as some additional money and the use of volunteers.

One of the things I think that's instructive, too, in looking—as I mentioned earlier, rural hospital closures are going to cause people to travel farther to be able to get health care services. In at least

some of the cases, those 11 hospital closures, I think if we had good rural transportation services or a good network of rural transportation in those counties, some of those hospitals might have survived. I think it also has an impact on the survival of rural hospitals.

Senator PRYOR. I think that's a critical point right there. I think they would have survived, I believe, with transportation services. Yes, Ed?

Mr. HAAS. That's where exactly I think our—and I didn't go into fully our partnership with the CARTI in Searcy. Those are the types of things that I think must be done. If we are to get people in specialized care travel, those people that are long distance, then I believe that we are going to have to have support from the health are facilities themselves. And I mentioned the fact—I don't know if I mentioned the fact that the CARTI provides our area $25 a day to operate that vehicle to bring their people in. That's the type of support we're going to have to have. I think what's going to have to happen is, the health care facilities are going to have to realize that we don't get all the money they think we get from the Federal Government, and I think that's their general perception. And we have been told that from time to time, "Hey, you get the Federal dollars. You're supposed to do this." I mean, it's looked at as though we're supposed to do it. Okay? And I think what needs to happen is that partnership needs to happen to where we can operate those systems for their benefit and for the benefit of the elderly.

Senator PRYOR. Jim, did you want to add anything?

Mr. LOFTIS. Yes. Ed spent a lot of time talking about the aging fleet, and that is a major concern to service providers and area agencies, as well the Division of Aging and Adult Services. But when you think about it, just the purchase of equipment, that's just a small component in the transportation costs. I mean, you have to have insurance on that equipment. We have 10 vehicles in our fleet and pay $13,000 year just for the liability coverage on them. You know, there's gasoline and staff. So equipment is just a small part of the whole cost picture for transportation.

Mr. HAAS. It's about a third of the cost. I might add, it wasn't long ago that one of the reporters at either the Democrat or Gazette had called our office and was talking to my supervisor and myself about the transportation system. And they happened to ask me on the telephone, "Well, what does it cost to operate a vehicle?" And I said, "Well, $13,000 to $15,000 per year." And their next statement was, "That's not very much." And I said, "Now multiply that times 340 vehicles," and I hear the calculator go on the telephone, and the next thing I heard was, "Oh." I said, "That's $4.7 million, isn't it?" And she said, "Yes." And I said, "People don't realize what it takes to do it."

Senator PRYOR. That's $4.7 million statewide; is that right?

Mr. HAAS. Statewide.

Senator PRYOR. For 300 and some odd——

Mr. HAAS. Three hundred forty vehicles.

Senator PRYOR. What could you do with, say, $900 million? That's about the cost of a Stealth bomber, B–2 bomber. You could do a lot with that, couldn't you?

Mr. HAAS. We sure could. Again——

Senator PRYOR. That was a cheap shot, I know. But anyway, go ahead. Go ahead, Ed.

Mr. HAAS. I liked it. I guess my point is——

Senator PRYOR. It makes sense, but——

Mr. HAAS. The point I really want to drive home is, what vehicles we buy are standard vehicles. And I mean we have complaints from older people about getting on a 15-passenger bus. We are not buying expensive vehicles. We're talking about a 15-passenger that may have a radio, and it costs $18,000. Senator Pryor, I can remember when I started working in this program about 12 years ago that that same bus was $10,000. I mean, that's the cost of doing business—the increased cost of doing business today to operate a system.

Senator PRYOR. Any more comments from this panel? We want to thank you. Let's give them a big hand.

I'd also like to announce that we had a special certificate prepared for Mr. Clarence Anderson today, who is our friend who could not attend, and this certificate will be delivered to his home, and we want everyone to know that. And James, I hope you will tell him how sorry we were he could not come.

Our next panel is Dr. Catherine Donald, Capitol Pharmacy, Little Rock; Cynthia Brandon, a private attorney in Little Rock; and Dr. David Lipschitz, the Director of the Geriatric Research Education and Clinical Center at the John L. McClellan Memorial Veteran's Hospital.

Now, this is going to be a unique panel, ladies and gentlemen, and very interesting, because we've talked about health needs and we've talked about transportation needs in rural America. Now we are going to talk about some of the nontraditional long-term care issues for the elderly. And we would ask at this time if Dr. Donald, if you would, make your statement at this point and then we might have a few questions.

STATEMENT OF DR. CATHERINE DONALD, CAPITOL PHARMACY, LITTLE ROCK, AR

Dr. DONALD. Good morning, Senator, ladies and gentlemen.

Senator PRYOR. Thank you for coming.

Dr. DONALD. I am very honored to be here today.

I am a pharmacist. This is my home town of Little Rock, I am a working pharmacist. That's the title, I chose for myself because I am out working with the public on a daily basis, morning, noon, and night.

I chose to be a pharmacist because I feel that it's one of the most trusted and respected professions available to me. I attended today simply because I wanted to speak on this issue to the Committee of Aging from a pharmacy point of view.

Pharmacy, as a whole, is probably going to be the bad guy in this whole dilemma. But, I feel like you, I, and the Senator, we've got to speak up and voice our opinion on how we feel on this issue. Because if we do not, then nothing will be done. On a daily basis, I'm out there with the customer, with you, talking to you about your prescriptions, your medications, your needs. You see these prices. I see these prices. We all hold our breath when we get a prescription

filled because we don't know if we can afford it. This is what I deal with on a daily basis. You know, we don't expect to get sick. We don't expect these high prices. But, this is something we have to deal with. This is a part of our budget.

On a daily basis, I deal with true-life stories relative to high drug prices. I've seen mothers with newborn babies, that don't have money to pay for prescriptions. You say, "Well, that's not bad." These people don't have $6 or $7 to pay for an antibiotic for a newborn. She has to spend this money on food, clothing, baby milk, and so forth.

And, then you look at the other end of the spectrum. You've got our senior citizens. They have a fixed income. Once you spend that, there is no additional funding from anywhere else. Now, the questions began—What I can get refilled? What medication can I do without? What will my money buy? And, to me this is second class medicine. It's bad medicine. We should not have to make a decision one way or the other—if this is what I want or if this is what I can afford. This should be available to us as Americans.

The part that I dislike the most about this dilemma is that I'm the one that's blamed for the price increases. I'm the one that has to take the complaints and the criticism for the price increases. I am the one forced to pass along to the patient all the price increases that I receive from the drug manufacturers.

So, I've decided that I'm going to take a stand. I am going to voice my opinion. And, if the Medicaid program is to prosper, if we, as Americans, are to prosper, we have to solve the rising drug pricing issue. This new bill Senator Pryor has submitted to Congress, S. 2605, it mandates two goals.

One, it mandates that Medicaid recipients have access to the medications that the doctor prescribes. It has no upper limits. Currently, in Arkansas a Medicaid recipient receives only six prescriptions per month. Therefore, if he's a heart patient or a diabetic, and/or has more than one medical condition and needs eight prescriptions, he's got to figure out how to pay for the other two.

The second part of this bill says it will create an opportunity for the State to establish a money savings Medicaid drug price negotiation program. However, to do this, Senator Pryor has to negotiate with the drug manufacturers. He's got to go to the table, roll up his sleeves, and go to work. This is the only way we can get our drug prices down.

I think this is a practical solution to a serious problem. I think you, I and the people of Arkansas can make this work. We can support out Medicaid recipients. We can support our elderly. We can support our poor. But somewhere along, we have to ask for help. And my form of help is to ask Senator Pryor go to the negotiation table. So far, three major drug manufacturers—that own a bulk of the industry—have come to the table and agreed to negotiate to bring down their drug prices. We want Senator Pryor to go back to the table again and get other drug manufacturers to negotiate their prices. If we're going to get the State budget intact, we've got to get them to this table and we've got to negotiate.

Senator, I also want to bring to your attention the fact that the drug companies are charging outrageous prices compared to what they charge in other countries. For example, I have data that

shows that our Canadian friends pay substantially less for their life-saving medications. Let me give you some examples. For the drug Naprosyn, taken by many elderly to relieve the pain of arthritis, U.S. citizens pay 42 percent more than Canadian citizens. Dyazide, which is used frequently to control blood pressure, is available for 53 percent less in Canada as compared with the United States. The examples go on and on. Why are we in America paying such outrageously higher prices than other countries for the same drugs?

In conclusion, I would like to say, Senator, I would like to thank you for this bill because it's a solution for skyrocketing prescription drug prices. It's something that we, as Arkansans, should support because it's our future. It's something that we are going to have to deal with on a daily basis. If you choose to ignore it, you're ignoring something that is very important to you, to your family, and to your friends, because they will be affected by this, you will be affected by this, and I'm affected by it. Thank you.

Senator PRYOR. I would like to ask—and I'm breaking with my tradition here just a moment. Did you finish your statement?

Dr. DONALD. Yes.

Senator PRYOR. That was a very good statement.

[The prepared statement of Dr. Donald follows:]

STATEMENT OF DR. CATHERINE DONALD, PHARMACIST
before the Senate Special Committee on Aging
August 21, 1990

SKYROCKETING PRESCRIPTION DRUG COSTS: BAD MEDICINE FOR OUR STATE'S POOR AND ELDERLY

Good morning, Senator Pryor, ladies and gentlemen. I am honored to be able to testify before this special field hearing of the U.S. Senate Special Committee on Aging in my home town of Little Rock. I graduated from the University of Arkansas School of Pharmacy in 1984 and currently practice at the Capitol Pharmacy here in town. Before I was licensed as a pharmacist in Arkansas, I worked as a pharmacy technician for ten years.

I am proud to be a pharmacist. Year after year, pharmacists are rated as the most trusted and respected health professionals in America, even higher than the clergy. As a pharmacy student, I never thought that I would have the opportunity to testify before a Congressional Committee on issues relating to my profession. However, I come to you here today with some disturbing news about what prescription drug prices are doing to our State's poor, elderly, minorities and other patients who cannot afford their medications.

Because I am on the front-line in attempting to get the needed medications to patients, I have some true-life stories which show how high drug prices result in bad medicine. It is very difficult to see mothers unable to fill prescriptions for their newborn babies because they don't have money to buy the needed prescribed drugs. Their limited resources must be spent on food and clothing instead. More and more, people are forced to make these choices. Many seniors, for example, are cutting their drugs in half to stretch out the prescription because they just cannot afford to have it refilled that month. This is just bad medicine.

Unfortunately, pharmacists often are blamed for price increases. Time and time again seniors think that I am getting rich because of high prescription prices. This is just not true! I am forced to pass along to the patient all the price increases that I receive from the drug manufacturers.

The state Medicaid program is feeling the impact of rising drug prices. The Arkansas Medicaid drug program has had to place a limit on the number of prescriptions that a patient can receive at any one time. For example, if an elderly person needs 8 prescriptions filled, and the state can only afford to pay for 6 because of high drug prices, what is the patient going to do? He or she ultimately has to make the decision about which prescription can be filled. What we have now is a system of

second class medical care for our State's poor that rely on Medicaid for needed medications. If this problem is not addressed soon and manufacturers' prices are not brought under control, we will have a crisis in the Arkansas State Medicaid drug program.

Senator Pryor, you have developed what I think is a very reasonable approach to getting Medicaid drug costs under control. The Pharmaceutical Access and Prudent Purchasing Act of 1990, in my mind, will be good for the State of Arkansas and Medicaid beneficiaries. The bill addresses two major goals: it mandates that Medicaid recipients have access to the medications their doctor prescribes; and, it saves money for the State by negotiating with the drug manufacturers over the value of their drugs. It will certainly be a big help to the patients that I serve.

Your bill is a practical solution to a serious problem that is evident to me, to you, and I think to all the people in this room. It is too bad that the drug manufacturers have made it clear that they do not want to bargain with the Medicaid programs. They want to continue to charge Medicaid unfair and high prices for drugs. However, some companies now seem concerned enough about the situation and have come forward with their own plans. If these leaders of the drug industry -- Merck, Pfizer, and Glaxo can come forward, then hopefully the others will shortly follow. We need to stop the drug companies from discriminating against the patients I serve. States would not need to restrict the number of prescriptions that Medicaid beneficiaries would have filled if the drug manufacturers would just give us fair prices. I don't think that this is too much to ask.

Senator, I also want to bring to your attention the fact that the drug companies are charging American citizens outrageous prices compared to what they charge in other countries. For example, I have data that show that our Canadian friends pay substantially less for their life-saving medications. Let me give you some examples. For the drug Naprosyn, taken by many elderly to relieve the pain of arthritis, U.S. citizens pay 42% more than Canadian citizens. Dyazide, which is used frequently to control blood pressure, is available for 53% less in Canada as compared with the United States. The examples go on and on. Why are we in America paying such outrageously higher prices than other countries for the same drugs?

The bottom line, Senator, is that skyrocketing prescription drug prices are resulting in bad medicine for Arkansas citizens. Your effort to bring costs under control in the Medicaid program is a good first start. We need you to keep after the drug manufacturers, however, and keep the pressure on them. The health of our citizens depends on you. Thank you.

Senator PRYOR. Accompanying Dr. Donald, we have Mr. Norman Canterbury, who is representing the Arkansas Pharmacist's Association, and I'd like you, Dr. Donald, and also Norman Canterbury to know and the audience to know that every time I get up and make a statement about the tremendous increase in drug prices, pharmaceutical manufacturers raising the prices, it is not the fault of the local pharmacist. Don't blame your local pharmacist.

Dr. DONALD. Please.

Senator PRYOR. And we see for example right here—Kris Phillips is putting that up. We see here in the last 7 to 8 or 9 years, we see a general price increase of 28 percent in the general price, in the cost of inflation. We see prescription drug prices going up by 88 percent. I think that is indefensible by the pharmaceutical manufacturers. And what they do is, they pass this on to the druggists and the pharmacists like Dr. Donald, and you're the ones that get the flak. You're the ones that get the criticism and the heat.

What our legislation is attempting to do is to bring in line some of the variations of prices. For example, the Veteran's Administration negotiates. They negotiate a price on certain drugs on a list, a formulary. And they do a very good job, the VA does. And they say, "We are going to buy these drugs if you'll set them at the right price." So the VA, for this bottle of Proventil—this is an anti-asthma drug. They pay $8, the Veteran's Administration pays. Okay. What does the Medicaid program out in the State pay for the very same bottle, the same drug, and the same number of capsules? Twenty-four for the same bottle, the same number of pills.

We find that all across-the-board throughout the pricing techniques of the drug industry. And as I say, they're gearing up now to defeat this legislation. They don't want to competitively bid. Two or three companies, Merck and one or two more, have made overtures recently saying they're willing now to start selling at a much—at a less expensive rate. But I think that's fine, but I don't know who the president or the chairman of the board of Merck is going to be this time next year. And I think we're going to have to put this in the law and I think we're going to have to force competition in this field.

And finally on the pharmaceutical manufacturers, you'll see many, many ads. They've run about 14 advertisements in the major newspapers, the Washington Post and the New York Times. And they're talking about all the money that they're spending to bring a new drug to the market. They're talking about trying to find a cure for Alzheimer's and Parkinson's disease and cancer and all of the major illnesses and problems that we face. But what they don't tell you is that the Congress—to encourage them to find these cures, the Congress gives them a tax write-off for that. We give them a research and development tax write-off. So they're really not out any money.

We give them the Food and Drug Administration protection. We give them a 7-year monopoly with a patent. And then what do they do? They go off to Puerto Rico and establish their manufacturing plants to manufacture these drugs. Why? Because they don't pay any income taxes in Puerto Rico—Federal or State. So they've got it going both ways, and they're the only part of the health care delivery system today in our country that is not sensitive to doing

their part in the health care delivery chains of trying to bring their prices into order.

But I'll tell you, on this issue, we may not win this year, but we're going to win next year or we're going to win the year after that. We are catching the attention of the pharmaceuticals manufacturers. The profits are at an all-time high. They're gouging us. As a result, we're having to cut back other needed services.

Norman, I may ask you a question or two later, too, but let's go next—we'll get off the drug pricing. We may come back to that in a moment. Let's go to Cynthia Brandon, who is not a pharmacist but a lawyer. And she does a lot of legal work out there, and she is going to tell us about some of this legal work that she is doing as an advocate for the elderly. And if you would, Cynthia, we'd appreciate your comments.

STATEMENT OF CYNTHIA BRANDON, PRIVATE ATTORNEY, LITTLE ROCK, AR

Ms. BRANDON. Thank you. Senator and members of the audience. I'm happy to be here, but I'm confused as to why I was invited because most of the people you've heard today, they deal with the elderly every day. I do not. I have a private practice. I'm a businesswoman. I've been in business for 2 years by myself. I don't get Federal funds for anything I do. Ninety-nine percent of the time, I think I don't get paid for what I do because my clients are just regular people. I do represent a lot of older people, mostly through court appointments and through referrals from friends and other agencies. That's because I used to be an attorney for Central Arkansas Legal Services. They provide legal services for the elderly in the Pulaski County, Lonoke, Faulkner County area.

In dealing with the elderly, they are just like everybody else. They get sued. People want to break contracts with them. People want to take advantage of them. People want to hit them with cars. They want to hit them with huge medical bills that they can't pay. They just have the same problems that you and I do. They like to get divorces sometimes. But I see them most often in situations where either the State is coming in to take over choices for them through protective care or their family is coming in wanting protective care for this loved one. These are guardianship actions, and I get appointed to quite a few of these through the courts. I've also handled a few of them for the Department of Human Services.

I have a lot of problems with guardianships in this State. I am not familiar with how other State laws act. But in this State, it is extremely easy to get a guardianship over an older person with very little proof in court, and I find oftentimes they're done for convenience of the family. And that's sad to say, but it is true. They are oftentimes taken too soon or the other side of the coin, a guardianship is taken too late.

I made an extensive written report because I knew I couldn't say much in 5 minutes. But I have represented elderly persons when the State didn't intervene in time and they have been brutally abused physically, brutally abused. Their property is gone; the family has taken it, neighbors have taken it.

I cite one example in here where I was court appointed as an attorney to represent an older woman. She had been taken from her home over 6 months prior to my involvement. No legal action was taken to provide for a temporary guardian for this woman. When I went out, at the judge's direction, to secure her property, her home had been ransacked, even to the point of every piece of wiring in the home was gone. The toilet was gone. Everything had been ransacked and removed.

I don't think that that is a unique situation. I think it happens a lot. The elderly need legal representation. It's out there for them. I don't know how they know about me. They just find out about me word of mouth. There are a few agencies that direct elderly people to legal assistance. There's a program here in Pulaski County known as VOCALS. It's a cooperative program with Central Arkansas Legal Services and the bar association. We do a lot of good. I don't know an attorney in this town that doesn't take more than their fair share of pro bono work.

But let me tell you what it's like to deal with the elderly in Arkansas. I have represented people in Lonoke, Faulkner, and Pulaski County. Many of my clients don't have a phone. My practice is not like you see on L.A. Law. I don't go out and wine and dine the night before I'm in court, and then show up with my briefcase and razzle and dazzle the jury. They don't tell you the 5 to 10 months work that went before Kuzak walked into the courtroom and made that presentation.

In dealing with my regular clients, I pick up the phone a lot of times so they don't have to come to my office. But in dealing with the elderly, many people don't have telephones. And I have been amazed in the last 4 years. I've been a licensed attorney for 4 years, and I am just amazed at how many people in Arkansas don't have telephones. I cannot pick up the phone and say, "Miss So and So, I need your Social Security number because I have to attach it to the bottom of this document that I'm presenting to the court." What that means for me in private practice—because I don't have a paralegal to go do it, I don't have a secretary to go do it, I've got me—I get to drive to Lonoke County. I get to drive 40 miles to ask Miss So and So what's her Social Security number. Tell me again what's the name of that witness. Those are time consuming factors that prevent me from doing my job as an attorney. They're not things an attorney should have to do, but they have to get done some way, and I'm not aware of agencies that are available to get these people to me.

When I worked for legal services, that was one of the worst nightmares. Waking up on a morning that you have to be in court with a client, and you've got to make arrangements beforehand to get that client there. And there is nobody there to pay you to go get them. That's something that those legal services attorneys, they get reimbursed a little bit for their mileage, but they do a lot of that out of their own pockets. And as a private attorney, I know I do and I know a lot of other attorneys do. You go and you get your client to court, and you may have to leave at 7 o'clock in the morning to drive to Lonoke to get your client, who is being sued in Pulaski County, bring them over to Pulaski County and get them up there in that little walker, you know. And it's slow. It's a slow

process. And to an attorney, time is money. And as I say, there's nobody paying me for that time. So those are problems that I have in representing the elderly.

Another specific problem besides the transportation is talking to the elderly client. I find the agencies, that I have dealt with in handling my clients' problems, don't know how to talk to old people. They're in a hurry. I've got to see 25 people today and I don't have time to listen to Aunt Sue, who took my money 25 years ago, or we just don't have time to listen to the elderly. And this is a real problem for an attorney. The elderly take time to tell you what the problem is, you know. They have lapses of memory, that's not their problem—that's not their fault. It's just a fact of life.

They don't remember who signed that contract. They don't remember who was there when they did a certain thing. They don't remember the name of the person that mowed them down with the car that now we're trying to sue. They don't have the information that many times an attorney needs. It takes, I would say, two to three times more of my time to investigate an elderly person's problem than it does a nonelderly citizen who can give me information I need. Many elderly people cannot communciate at all, and representing them in court is a nightmare. It is an absolute nightmare. But we do the best we can.

In closing, I would like to say that I know that there are attorneys in the private sector who are more than happy to help the elderly. We don't know the elderly who need us. We can only go through the agencies that we're aware of. For me, it's Central Arkansas Legal Services. And believe you me, they do not hesitate to pick up the phone and call me because I used to work for them and they know they've got my ear, and they do it to all the other attorneys that used to work for them. But there are private attorneys who are available to help you elderly people and you agencies who are helping the elderly, but you've got to let us know about it and you've got to help us do our jobs.

And one of the things that I am asking the Senator to see if he can't help implement, there are transportation programs for medical problems. There need to be transportation programs to assist the elderly to get to their attorneys, to get to the legal assistance that's out there, and get there timely. Oftentimes, legal providers do not see the elderly until all the easy remedies are over with. They walk in my door and they've got a court notice for a foreclosure hearing. We could have stopped that foreclosure perhaps months before it ever got to that point, but now all the time has run out. Or they walk in and they've already been cut off from their Social Security benefits and they want me to fix it right then. Well, we go down and we file for a hearing, and it's 30 days or more before they're going to review the application. The person doesn't have their benefits. And then if we lose at that level, we've got to appeal. You're looking at 60 to 90 days. I have represented elderly people who have been cut off from their benefits for one reason or another who are truly entitled to their benefits who have waited a year and a half to get them started back, and that's not an exception to the rule. So I'm asking for your assistance in, make the agencies that are there to help the elderly. Let's coordinate all

of our efforts and I think we could help some of the legal problems be remedied for the elderly.

Senator PRYOR. Cynthia, thank you. Let's give her a round of applause.

[The prepared statement of Ms. Brandon follows:]

TESTIMONY OF CYNTHIA J. BRANDON
ATTORNEY AT LAW, BEFORE THE
UNITED STATES SENATE
SPECIAL COMMITTEE ON AGING

The issue of "Long-Term Care in the 90's: Spotlight on Rural America" being considered by this committee is such a multi-facet one that it is very difficult to concentrate my comments on only one or two parts of the whole matter. I as an attorney have had the opportunity in the past four years to represent many elderly persons in a wide variety of legal matters because they are just like most of us, they find themselves in need of legal representation from time to time. I have represented elderly persons in estate matters, divorces, contract disputes, real estate transactions, landlord tenant matters, business matters, and the list could go on indefinitely. There are certain legal problems that are unique to elderly persons, and more importantly, there are definitely problems in representing older persons that I as an attorney generally do not experience otherwise. I will attempt to address the unique legal problems that I feel exist for the elderly and then some of the difficulties and frustrations I have experienced in my representation for them.

When people reach the status of senior citizen, their lives do not shut down by any stretch of the imagination but they do become more and more dependent on others for their day to day existence. As a result of this increasing dependency, elderly persons gradually lose control over choices that we all assume will always be ours to make. Choices such as where to live, with whom to live, what to eat, how to spend time, how to spend money, etc. **Long term care** does not just mean where a person will live out the remaining years of life, it encompasses where, how, with whom and also the quality of life style, including the level of independence and dignity that person will experience until death.

UNIQUE LEGAL PROBLEMS FOR THE ELDERLY

Due to a variety of reasons such as increasing health problems, decreasing ability to make the best decisions for themselves, fixed incomes, society's attitude that elderly persons can not function on their own, and immobility, many older persons become involved with our legal system as a result of state intervention for protective care or family intervention for the same. I have represented both the elderly persons in guardianship actions and at other times the persons seeking the guardianship of a loved one.

The biggest problem I have witnessed in guardianship actions is that of timing. Often well meaning family members try to intervene too early in their loved ones life, resulting in many unhappy feelings on both sides and always ending up with the elderly person loosing self esteem and their own sense of value as persons. The other side of the coin is when intervention does not happen soon enough, the elderly person may be harmed by either themselves or others and all too often his or her estate is partially or wholly lost.

In my representation of elderly persons in guardianship actions I find most are frustrated with the lack of control they feel over their lives. They have to accept fixed incomes; family members' disregard for their wishes; bureaucracies and constantly changing and unclear regulations pertaining to public benefits such as Social Security, medicaid, food stamps; and immobility. Our society has made so many regulations limiting their choices relating to their lives that they often just give up and consent to a guardianship they may not need. For example, I have seen guardianships sought by families simply because the elderly relative can not drive or get about easily or because he or she is slow in making decisions or in communicating. A complete guardianship over the person and estate is sought to make it easier on the family with little or no regard being given to less restrictive solutions which might allow the elderly relative to continue independently.

Our society has made it entirely too easy to warehouse older individuals in nursing home facilities simply because it is easier to put the individual somewhere, take away their choices and rights to make decisions for their own lives and keep them out of sight and thus out of mind. The standard for proving the need for a guardianship in Arkansas is very vague and subjective and I have found it to be a very vulnerable statute for abuse by persons who either are motivated by greed or simply convenience.

The other side of the coin, where intervention has come too slowly is where my practice has brought me in contact with the legal problems elderly persons experience through no fault of their own. Many of my elderly clients have been persons living in nursing homes. I must say that most of them have confided to me their desires to die soon rather than continue living in long term nursing care. We have all had the experience of visiting someone in a nursing home and being knocked over at the entrance by the overwhelming smell of urine and then being very uncomfortable with the sense of despair and defeat evident in the faces of most of the residents.

Limited Social Security benefits, pensions, and/or family resources available for the expense of care for the elderly force most people at some point into nursing homes. It is my opinion that our laws and governmental agencies set up to protect and care for the needs of our elderly often times perpetuate and even enlarge the problems the elderly endure. I have represented several elderly persons recently where intervention by agencies set up for the specific job of protecting the elderly and their property have failed to act in a timely fashion and the results have been appalling. I will give a few examples to make my point.

I was court appointed to represent an elderly woman as her attorney ad litem and as the guardian of her estate about six months after she had been placed into a nursing home following an adult abuse investigation. Previous complaints

had been made concerning possible abuse to my client to various agencies but regulations, time and budget restrictions prevented intervention for a long time. During my representation I assisted the local Adult Protective Services caseworker in making a complaint to the prosecuting attorney for criminal charges against the person allegedly responsible for the extreme physical abuse and neglect this woman endured. Charges for theft of property were also filed. Due to the severe injuries sustained my client, she died before the criminal cases ever got to court. Both cases were dismissed.

This same client had been in the care of the State for over six months before the issue of a temporary guardianship was ever addressed. The agency who removed her from the home turned the matter over to the State Office of General Counsel who got to it in as timely a fashion as they could due to their limited resources and manpower. I learned from this case that elderly persons who come under the protection of Adult Protective Services in Pulaski County (which is the most populated county in our State) have only one attorney representing their interests prior to guardianship. He is also required to represent persons in other counties. It is not surprising to me that the petition for a temporary guardianship was not filed with the court for over six months as I am sure that attorney handles hundreds of similar cases every month. The delay in filing for a temporary guardianship allowed the family member charged with the abuse and neglect to basically take everything my client had in the way of personal property and of course none of it was ever recovered.

I currently represent another woman in a similar capacity who may eventually be cut off her medicaid coverage because she was incapacitated to the point of being incapable of communicating her desires about returning to her homestead. There are medicaid regulations that prohibit a person from owning none exempt property, personal or real, in excess of $2,000.00. When I took over her case I found her Social Security and Rail Road Retirement benefits were still being

directly deposited into an account and although she had been in nursing home care for almost six months via state protective intervention, the proper steps had never been taken to allow the nursing home access to these benefits to pay for her care. This problem being remedied I then learned from a medicaid employee that my client would soon lose her eligibility for medicaid because of the unexempt status of her home. I can not communicate with my client due to her disabled state so I am having to act as her guardian and am attempting to sell the property. I am experiencing much trouble in finding a company to list the property because of the horrible condition it is in. The current condition of the property developed after she was removed from her home by Adult Protective Services almost nine months prior to my involvement. This lapse in time resulted in the total ransacking and stripping of her house. All pipes, fixtures, and even wiring have been removed and I found the house was being inhabited by transients. Here again I found that the system and agencies set up to protect this woman functioned so slowly her property was virtually destroyed. Because of limited time and resources again the agencies were unable to even fully investigate the issues of the abuse, no conviction resulted from their efforts, and every personal property item my client owned was either stolen or destroyed before anyone got all regulations met.

These are only two examples of guardianship actions in which I have been involved where delays in taking the proper legal steps to protect the elderly clients or their property caused shocking results that I would never have imagined happening had I not witnessed them first hand. I cannot presume that these are only isolated cases because the agencies set up for the protection of the elderly are so under funded and staffed it is inevitable that these results will most often happen.

Other legal problems which I find are not necessarily unique to the elderly but which are common legal problems for persons in that age category are the myriad of legal matters that pertain to Social Security, SSI, Medicaid, and food

stamps. Time will not permit me to address these individually but I will comment that during the four years I worked at a legal services agency I found that my elderly clients in particular experienced alot of problems in the receiving of these various benefits.

Much of my legal representation of the elderly in these administrative court matters has involved unclear agency regulations and often times impossible guidelines. Many of the agencies set up to administer benefits to aid the elderly seem to have no understanding of the persons they are trying to service. For example, most elderly people are immobile to a certain extent in that most no longer drive. In our county we have a public transit system but many elderly are not able to fully use it for logistical reasons. In the extreme hot or cold months in Arkansas, many elderly just cannot physically get out and walk to the bus stops and wait. There is generally inadequate seating for passengers waiting at stops. Additionally there are many elderly persons who are unable to get out of their homes or even the nursing facilities they may be in. Many agencies fail to take this fully into consideration. I do not know whether this is because of budget restrictions but I do know that most of my clients have advised me these agencies do not make home calls.

The never ending change in regulations pertaining to programs is confusing to many as it is to me. Agencies often feel that sending notices in the mail remedies the problems with changes but I can say that in my representation of persons, some notices I have read I could not understand Many times they have been so unclear that litigation has resulted so that a judge could interpret them for the public. It seems that simplicity in language could help alleviate many of the problems our elderly face in understanding what benefits they may be entitled to and how they should go about obtaining.

PROBLEMS I HAVE EXPERIENCED IN REPRESENTING THE ELDERLY

I find in dealing with the elderly, one has to take alot of time with the person. In my capacity as a lawyer I find that I spend much more time just trying to get at the heart of my client's legal problem because of limitations my client has. For example, I am used to just picking up the phone and calling clients and getting whatever information I need or I just have them drop by my office. This is not very often possible when I represent elderly persons as many of my clients do not have phones because they cannot afford them and often the ones living in rural areas do not even have access to a phone. Additionally, rural clients do not have access to public transit systems. Because of these limits I often have to travel to my clients and this is very time consuming.

When I worked for a legal services program I found it very frustrating that there was very little money for transportation of my clients for interviews or even for Court appearances. Now that I am in private practice I find much of my representation of elderly persons is on a pro bono (no fee) basis and this generally means I transport or travel to my clients out of my own pocket. As a member of the private bar I accept my ethical responsibilities to my community to provide legal assistance to those who cannot afford it but I like everyone else am limited on how many pro bono cases I can absorb plus these costs and still provide for my own livelihood.

Talking with the elderly is generally a time consuming effort and in particular communicating with my elderly clients always requires much more time than with other clients. This is not a fault of the elderly it is just a part of their lives. Elderly people sometimes loose their

thoughts or get confused on times and facts which makes representing them in legal matters a very challenging experience. It just takes time to illicit all the needed information to adequately represent these clients.

My clients have advised me that this lack of time is a problem they experience with almost everyone they come into contact with, especially the agencies who they go to for help. It seems in efforts to streamline processing to enable themselves to provide for more persons these agencies often times cause the elderly more problems.

I also find in dealing with the legal problems of the elderly these legal entanglements have gone on for such long periods of time without the person having legal representation that a simple solution is no longer available. It is often the case that I do not get contacted until the most extreme hardships are about to take place. It is my sincere belief that many elderly in Arkansas, and particularly in rural areas, simply do not know how to access legal assistance. When I worked for the legal services agency I heard over and over "I did not know your agency was here to help me." Legal service budgets are as tight as anyone's and community outreach is a costly venture for most communities. I know there are many attorney's such as my self who would be willing to aid elderly persons with legal representation if they knew of them. The Central

Arkansas Legal Services and Pulaski County Bar Association joint program, VOCALS, is an excellant program trying to bridge this problem not only for the elderly but for the low income population. This program unfortunately is only located in Pulaski County and I am unaware of such similar efforts elsewhere in the state.

In preparing my comments for this committee I spoke with two other attorneys and a community liaison person and they all reiterated these same complaints. The elderly are being shoved out of sight, their complaints are not being heard, they need to be educated as to the agencies and services available, and they just need to be respected as persons not numbers. One attorney advised me that she is representing a gentleman residing in a nursing home, whose daughter has a guardianship over his person and estate. This man was told by staff that he could not leave the facility without his daughter's permission and that he could not even have contact with his attorney. These fact scenarios are abundant and it is apparent that the elderly are not aware legal help is available.

I hope that my comments, though scattered, to cover much, will be helpful to this committee and I remain available to you.

Respectfully Submitted By:

Cynthia J. Brandon

Senator PRYOR. It really gives the rest of us an insight into what you're going through and a lot of other fine attorneys are going through in representing people where you really don't get payment and justified with all of the time and expenses that you're out yourself. We appreciate that.

Do you think the bar association is doing enough in letting the elderly or the agencies know of the availability of certain attorneys, or what should the bar be doing that it's not?

Ms. BRANDON. I think the Pulaski County Bar is doing an excellent job. The VOCALS program is servicing—well, I know they have more than 400 members on the VOCALS program. Every VOCALS attorney makes a commitment to take at least three cases a year. That's 1,200 cases a year that attorneys are taking for no money and they're paying those expenses 99 percent of the time out of their own pocket just because they don't want to burden the legal services program. Hey, reimburse me for that filing fee I paid. That was 89 bucks out of my pocket. You know, it's there and you can go through the procedures to get your money back, but many attorneys don't want to do that. They feel like that's part of their commitment to provide pro bono services. In Faulkner County, they don't have it. The private bar is working to reach the community, but I'm not aware of an organized program.

Senator PRYOR. The Pulaski Bar seems to be doing fairly well in this area.

Ms. BRANDON. Yes.

Senator PRYOR. What about the Arkansas State Bar Association? Are they——

Ms. BRANDON. I'm a member of the Arkansas State Bar Association. And quite honestly, I'm not aware of any program that they are heading up. Now, I know that there is an ACEL program in Pulaski County. They provide services through the Arkansas Bar Association to the elderly. But there again, it's communication that's a big barrier because I get bombarded with mailings from different agencies every day that go in the trash because I don't have time to read them. Maybe these agencies should come to my bar association luncheon and say, "Hey, we're here. Here's the phone number." That's all I need to know is just who to call and how to get in touch with them quickly.

Senator PRYOR. Three weeks ago, I was invited I—don't know why they asked me, but I was invited to speak to the American Bar Association in Chicago on the issue that we were just talking about here, what can the American Bar do in this whole area, and I did not get to deliver that speech because the Senate was in session on that Saturday. And in fact, we had a CIA briefing scheduled at 4 p.m. that afternoon which I went to on the Mid-East crisis, so I was in Washington, did not get to visit with the American Bar. But I am going to make a very, very great strong pitch that the American Bar, I think, can do more in this area, and I think that they may be willing to. I think there's a new sensitivity to it.

Ms. BRANDON. Well, I agree with that, Senator. I think that—you know, I deal with attorneys; that's what I do for a living. And everybody I know is an attorney. And everybody I know is doing pro bono work. They're not asking for these people to pay them for the services that are being rendered. But I hear over and over and

over again, "Well, why are you getting so many of these cases? Nobody calls me to do this." So I think that the American Bar does need to be informed of the need nationwide, because I'm sure Arkansas and Pulaski County are not unique situations. Elderly people everywhere have problems.

Senator PRYOR. You know, I was—I'll shift gears in a moment. You're talking about the elderly being vulnerable. We have found, since the repeal of catastrophic health insurance coverage—we repealed that last year, as everyone knows. And now we have nothing out there much. We retained one or two little slices of it. But as a result, when we did repeal it, we found a flurry of activity of certain, and I must say sometimes unscrupulous, individuals and companies trying to sell the elderly medigap insurance policies. Now, I tell you—by the way, I think it would be interesting. In the last year, how many of y'all have gotten mail on a new medigap insurance policy? Okay. Quite a few. I am not going to ask how many have bought those policies because some are good; many are not.

We held a hearing about 6 months ago on this issue and one of our witnesses was in the Florida State—no, he was in the Federal penitentiary in Florida. And he testified by live satellite before our committee from his jail cell. He had made $300,000 the year before selling medigap policies, some were worthless, to senior citizens in the Florida area. And he told about the techniques, once you get in the door, don't leave until you have gotten the cash or the check from that elderly citizen.

So the Aging Committee, one more service that we do perform is, we've published this, a guide to purchasing medigap and long-term care insurance. This was published only in April of this year in response to many, many complaints and concerns. We're also working with the State Council of Insurance Commissioners in all of the 50 States to get them to clamp down on some of these unscrupulous people. I don't—Portia, do we have copies of these out there? I think there are some extra copies.

Now, if you think you don't understand your insurance policy, don't feel wrong. I'm a member of the Pepper Commission. There are six Congressmen and six Senators and three people, three appointed by the White House. We're supposed to be the experts in the United States on insurance coverage and illness and growing—all of these issues that we're talking about. We gave ourselves a test, the 15 of us. We took our own insurance policies that we had. We were given a test on what our policies covered. All of us flunked the test. So don't feel badly if you don't understand your policies because most of us don't. But pick up this little guide. I think it will give some helpful hints.

Cynthia, we thank you. I may have another question or two in a moment.

Let's move now to another very distinguished individual, Dr. David Lipschitz. And David is the Director of Geriatric Research at the John L. McClellan Memorial Veteran's Hospital. He has been a witness for us on several occasions. He's always got something wise to say, and instructive. And David, we look forward to your statement.

STATEMENT OF DR. DAVID LIPSCHITZ, DIRECTOR, GERIATRIC RESEARCH EDUCATION AND CLINICAL CENTER, JOHN L. McCLELLAN MEMORIAL VETERAN'S HOSPITAL, LITTLE ROCK, AR

Dr. LIPSCHITZ. Thank you very much, Senator Pryor. It's really an honor and a privilege for me to testify before you and this audience. I've been asked specifically to address the issue of nutritional problems in long-term care, which is an area that I have had a special interest in for many years.

Malnutrition is really a very common problem in older people, and it is particularly severe in those with chronic diseases, in elderly individuals who are institutionalized, or those who are homebound as a consequence of chronic illnesses and functional dependency. It really is a fallacy to believe that serious nutritional problems exist in otherwise vibrant and healthy older people who, thank God, constitute the vast majority of the elderly population over the age of 65.

But on the other hand, if functional dependency develops, the risk of nutritional problems become substantively amplified. Now, the major nutritional problems that we have to deal with as clinicians both in nursing homes and amongst elderly who are homebound are firstly the problem of being significantly underweight, a very common problem in older people, a condition referred to as marasmus. The second is a loss of appetite, which is very, very common amongst older people who are ill. This is referred to as anorexia, and the third is protein calorie malnutrition, a condition very commonly seen in the long-term care setting. Major consequences of protein calorie malnutrition include a decreased ability to fight infections, greater, far greater tendency to develop bed sores, and a reduced ability to metabolize drugs normally, leading to increased risk of drug-induced side effects.

There is good evidence, I might add, obtained by work done at the University of Arkansas for Medical Sciences and the VA to indicate that malnutrition is associated with increased risks of hospitalizations, a more complicated and expensive medical course, and a greater risk of death. It's presence is often a cause of reversible confusion and memory loss that is often incorrectly diagnosed as dementia. There is also good evidence that the presence of malnutrition and anorexia is associated with a worsening quality of life. Finally, there is evidence that provided an accurate nutritional assessment is performed, anorexia can be corrected, weight loss reversed, and protein calorie malnutrition readily treated. It is highly likely that correction of malnutrition will decrease health resource utilization, minimize hospitalization, and improve quality of life. Malnutrition is universal in patients with bed sores, and failure to appropriately manage the nutritional component of the illness markedly impairs the likelihood of bed sores healing.

Based upon these facts, it's quite clear that nutritional problems constitute one of the few eminently correctable disorders found in dependent elderly with multiple, usually irreversible, chronic medical problems. Without a great deal of effort, nutritional problems can be easily recognized and appropriate interventions undertaken to correct the problem and prevent further deterioration.

It is particularly serious, therefore, that the nutritional status of long-term care patients both in the home setting and in nursing homes is frequently ignored by clinicians and usually inadequately treated. There are many reasons for the serious situation. Nutritional problems are rarely recognized by virtually all health care professionals, including many physicians, pharmacists, and nurses. This stems from very little formal training in nutrition that is aggrevated by the scant attention paid to long-term care issues in their curriculum and training programs. This probably explains why policymakers, government agencies, and third-party payers have ignored the provision of nutritional services—clinical nutritional services to homebound and institutionalized elderly. Access to trained nutritional professionals, registered dietitians, or others who specialize in clinical nutrition is woefully deficient, and reimbursement for nutritional services are virtually nonexistent. A case in point was the recent suggestion by the Health Care Financing Administration that dietitians be eliminated from the nursing homes.

I strongly believe that a concerted effort be undertaken to assure adequate nutritional intake, and optimal delivery of nutritional services. Food and nutrition services should be of the highest quality. There should be an effort to provide palatable and nutritional meals in a pleasant environment. From a clinical perspective, marasmus, anorexia, and protein calorie malnutrition must be recognized early, and prompt and appropriate interventions undertaken to mimimize their consequences.

These goals can only be achieved through a multifaceted effort which assures greater attention to health care professional training programs in long-term care issues in general and to nutrition in particular. These educational initiatives should be targeted at undergraduate students and should be an integral requirement of postgraduate continuing medical education. Focused and appropriate monitoring of nutrition services in long-term care is essential, and the cost of nutrition services should be accurately factored into reimbursement schedules for managed care.

Senator Pryor, I sincerely appreciate the opportunity of presenting this testimony to you. On behalf of myself and all members of the nutrition community, we look forward to working with you and your committee to develop realistic solutions to the difficult problems facing our elderly population requiring long-term care services. We feel strongly that attention to the nutritional needs will greatly benefit their sense of well being and quality of life, will minimize the risk of worsening functional dependency, and provide a cost-effective strategy to mimimize their utilization of expensive and scarce health care resources. Thank you, Senator.

Senator PRYOR. Doctor, thank you very much. How would I go about—if I wanted to go this afternoon and check on my nutritional intake, what would I do? What type of physician would I consult? Really, because I know you and I could call you on the phone, but maybe these other people don't know you. What do I do? What kind of doctor? Is there a particular clinic?

Dr. LIPSCHITZ. Well, there are a relatively small number of physicians who really specialize in nutritional issues, but those really

constitute a very small minority. It's generally accepted that the field of nutrition is really very poorly taught in medical schools.

I might add that aging and geriatrics and gerontology training leaves much to be desired, as well as training in long-term care. So the chances of you really identifying a specialist, if you were old particularly, who could counsel you on a specific nutritional problem, be it underweight or overweight, are really quite small. The answer, of course, lies in education. Through education, we can provide a greater deal of insight and understanding amongst the community and health care providers to improve this particular situation and others.

Senator PRYOR. Would today's typical general practitioner have the necessary training to tell me what to do or not—tell me what to eat or not to eat?

Dr. LIPSCHITZ. Well, I would say that the average general practitioner almost certainly could provide you with a credible counseling at your relatively young age.

Senator PRYOR. Thank you.

Dr. LIPSCHITZ. On the other hand, I'm not sure necessarily that the physician community really has the appropriate insights to provide the necessary expertise and monitoring of the complicated frail older individual with multiple medical problems. I think that managing nutritional problems in the face of multiple diseases is very difficult.

Senator PRYOR. Doctor, I think that as a result of this hearing, I think that you're getting ready to get a lot of phone calls beginning this afternoon, so——

Dr. LIPSCHITZ. Well, we'd be delighted.

Senator PRYOR. People wanting you to refer them to proper physicians and proper types of treatment. I may have another question in just a moment.

I wonder if I could go to Norman Canterbury now. Norman is with the Arkansas Pharmacists Association. We're switching back and forth a little bit here. And I'm wondering if you wanted to add anything to Dr. Donald's statement, Norman, or did you have anything to add?

Dr. CANTERBURY. Well, I would like to say, Senator Pryor—I have one right here. As a result, as she said, of the bill that's been introduced, S. 2605, the State has already had three companies to come to them and talk about negotiating those prices. But the key thing and the important thing is that if your bill goes away, then that's going to go away also. The pharmacists all over the Nation are becoming upset and brothered about these spiraling increases in the prices because they are the ones who have to face the people. They are the ones out there on the front line who have to talk to the people about their medication. The manufacturers, who are two or three doors back, never get to see the people and never get to talk to them. So it's quite a disturbance in the pharmacy community about that, and we appreciate what you're trying to do.

Senator PRYOR. I had an opportunity some weeks ago to have breakfast with one of the major—well, the president of one of the major pharmaceutical manufacturers. I resisted it for some while, but a friend of mine represented him, and I must say he's a lobbyist. And the lawyer used to be in the Senate. So he says, "Please

have lunch with Mr. So and So, the president of certain, certain company." So I finally said, "All right. Well, 8 o'clock, no longer 9 o'clock; I've got a busy day and I know he does." So he flew down from New York or New Jersey.

We were sitting there at the breakfast table, and he was telling me, he says, "Now," he says, "I don't understand what you're trying to do. You're trying to put us out of business." I said, "No, I'm not trying to put you out of business." And I said, "What I'm trying to do is very simple." I said, "Here's a medication that you manufacture and it's called Zantak. It's an anti-ulcer medication. And the Veterans' Administration pays $34 dollars for it. Medicaid, for the same number of capsules, pays $68. I'm trying to get the Medicaid program the same good deal that the Veterans' Administration is getting, and it's that simple."

So that's really what our legislation is about. And we've gotten the support of many, many of the pharmacists and the associations, not only in this State but around the country, which I very much appreciate because we're up against a very, very major, powerful adversary in the pharmaceutical manufacturers.

Dr. CANTERBURY. I might add this, Senator. When we meet with these people, the Pharmaceutical Manufacturer's Association, their answer to the problem is to raise taxes, to put more money into the program to keep raising those and keep raising the prices of drugs. But, they don't have to pay the taxes down here in Arkansas. We're the ones who have to pay the taxes. So what we need is a reasonable level of cost containment that people will get the medication that they need, but that they can get it—the Medicaid program will be the same price the Medical Center does, the Health Department does, or the VA does.

Senator PRYOR. Good. Dr. Donald, did you have anything to add?

Dr. DONALD. I would just like to say that the program was mainly based for Medicaid, to cut the Medicaid prices. But these same prices will be passed on to all consumers, those on fixed income and individuals who pay for his medication out of his pocket. We're passing the savings along to everyone.

Senator PRYOR. Now, I want to know this. People ask me all the time, they say, "Okay. You're trying to help the Medicaid programs. That's going to help the States. That's ultimately going to help the poorest of the poor in the country. What do we do about—I'm not on Medicaid and I pay, I guess, the top dollar when I am prescribed a prescription drug." What are we going to do about folks like me or anybody else who is not under Medicaid who doesn't get insurance coverage? See, there are about 430,000 people in our State with no insurance coverage whatsoever. What happens here? How do these people—do they get a drug benefit or a drug decrease in all of this ultimately?

Dr. DONALD. I say, they get a benefit, and that's simply because we do not charge you any more than we charge Medicaid. You get the same prices that we bill Medicaid. Actually most of it goes back to that manufacturer to pay for that high priced drug.

Senator PRYOR. So the Medicaid price basically becomes sort of an established price for the figure?

Dr. DONALD. Yes.

Senator PRYOR. So if we bring that price down, that's a first step maybe into bringing general drug prices down.

Dr. DONALD. Yes, it is. It's a good start.

Senator PRYOR. You know, they make these drugs in this country and they sell them, as you stated, for about half price in Europe. They sell them for half of what we—or sometimes even they sell them for less than half of what we pay. They gouge us and they pass the savings on over there in Europe and those 11 countries. We've had some charts on that. Norman, did you want to add anything?

Dr. CANTERBURY. I was going to say, the answer partially to what you're talking about for the private paying public is that the pharmaceutical manufacturers have different tiers of pricing for the same product. They give Europe one price; they give Mexico a price; they give Canada a price; and they give the United States the highest price. All right. Then within the United States, they've got tiered prices. They'll give HMO's a low price. They'll give hospitals a low price. They'll give VA a low price. They'll give the Health Department a low price. And then the private pay pays the high price. They have to make up for all of this other. And ultimately what we want to try to achieve with your bill is to get some parity on these prices to bring some of the high prices down and get the ones—they are actually giving the drug away. They actually give what you sometimes pay for these heart patches $1 a patch that you have to wear, not nitroglycerin patches, they'll sell to some groups for a penny a patch. Now, that's not right. And what we've got to do is get that cost up some and get your cost down.

Senator PRYOR. Good. I want to thank both of you for expressing very eloquently this point of view.

Cynthia, do you have anything to add? If you had one bit of advice for these folks here today, and there will be several people, I know, watching tonight on channel 18 the full hearing, what would you say that their most vulnerable area is to watch out for right now? What do you see out there that they should be most concerned about in the legal field?

Ms. BRANDON. Well, it's hard to make one choice. For the elderly who are particularly frail, I would say State intervention to protect them. They need to be accepting of that when it's necessary, but they need to not allow it to happen when it's not. You, as the elderly, oftentimes know what your capabilities are. And when people come in and say, "Oh, you can't stay home by yourself anymore," you need to look at that situation and help the people who are trying to help you make that decision.

It seems to me that we are warehousing our elderly in nursing home facilities, getting them out of sight and out of mind too often and too easily. And I caution you as the elderly population, stand up for yourself and don't go to that nursing home until you are ready. And I don't care if you make your family mad. Make them mad. I mean, they made you mad a whole lot of years during your life. So that would be my caution.

Senator PRYOR. Thank you, Cynthia. David, do you have any final comments?

Dr. LIPSCHITZ. Well maybe—could I make a little general statement?

Senator PRYOR. Yes.

Dr. LIPSCHITZ. I really feel that the health care delivery system in the United States has very serious problems. I think that it is primarily a provider driven acute care delivery system that is willing to do everything and anything to manage acute illnesses, and at all costs to save life. We will undertake the most heroic procedures on individuals with very little proven efficacy, but we will do little, if anything, to provide for the needs of individuals who have chronic illnesses and who require continued services. And I think primarily it relates to what we, at the moment, consider important. We're willing to reimburse enormously well for the management of an acute illness, but there are very little incentives for the health care community, physicians, and others, to make an honest living providing needed services to individuals of all ages who have chronic diseases.

And I think that it really boils down to a societal issue. We are going to have to make some choices. We can't have everything. And I think until we recognize that we have to develop some priorities, there will always be a continued crisis in the field of long-term care and there will never be sufficient funds available to do what's needed.

Senator PRYOR. I still go back to what Dr. Elders said earlier this morning in that 90 percent of all of this $600 billion goes to the last 30 days of a life. And that is where we are and that, to me, has grabbed me from the beginning of this hearing.

Now let's see. If we could, let's give this panel a nice hand. You may want to ask a question. Don't leave. I am going to ask Kenny Whitlock to come up, if he could. Here's a man that is the Director of Economic and Medical Services, the Medicaid program. I think, Ken, you're a fellow always under the gun and people are firing at you all the time. Kenny, come up and say a word.

Mr. WHITLOCK. Thank you. Thank you, Senator. This is the first opportunity I've had to really thank you for your piece of legislation which requires drug manufacturers to give a price break to the States. And regardless of whether that bill passes or not, it's already had a tremendous impact, as you know, in Arkansas. We are currently saving about a half a million a year as a result of that bill. We have had, as has been previously stated, three companies come forward; we have four that are interested. And we have signed one agreement and I have two that I am looking at signing in the near future. And I just want to say to you, I know the kind of pressures that you've been under from these people who have all the money in the world. And unless you have been in a position to affect a drug manufacturer's profits, I don't think you can really appreciate the kind of courage that it took to get this kind of a bill even proposed, and certainly to fight for it the way the Senator has. And we deeply appreciate that. And that's the kind of courage that we've come to expect from our junior Senator, anyway. So we appreciate it.

Senator PRYOR. I didn't know he was going to say all of that, I promise you. Thank you.

Mr. WHITLOCK. But I just would comment, we've heard a lot of testimony today about a lot of problems. A lot of those problems we could—our Medicaid program could have a tremendous positive

impact on a lot of programs that we've talked about. Our problem is that the cost of medicine, the cost of medical care, has increased tremendously. Our Medicaid program has doubled in the last 5 years, the cost of our program has doubled. And we are going to have to face those kinds of priorities, as we've already discussed. But we do have, I think, a budget proposed for our next legislative session which will help us maximize our program, maximize our services, and I hope people will support that.

Senator PRYOR. Thank you. Any questions of Kenny? Any questions of Ken from the audience here? Do you have a question for him? You get a very rare opportunity to talk to a guy like this and put him on the grill about some of these programs you've been reading about lately, but we'll be glad if anybody had a question. Okay. I thank you very very much.

I wonder if Herb Sanderson is still around. Herb was here earlier today. I don't see him. He directs our Aging programs in the State. We were going to ask Herb to come and sort of semi-conclude. We have about just 3 or 4 minutes left. I'm wondering if there is a message or a thought from anyone in the audience this morning. We don't want to talk about individual cases, but I wonder if there's a comment or a thought from anyone? Yes, ma'am.

FEMALE AUDIENCE MEMBER. I'd like to ask the question why medicine such as Tagament, which lots of the elderly people take for ulcers or irritable bowel syndrome—and my understanding that last year it was supposed to have come of age and go generic, but that was postponed. I'd like to know why.

Senator PRYOR. Dr. Donald, could you answer that?

Dr. DONALD. Tagament was supposed to go over the counter or, as you say, generic. But, you're dealing with patent rights. When a manufacturer puts out a drug, he has patent rights on that drug for a certain number of years, and Tagament still has a least 1½ years, as close as I can remember, to those patent rights. So there cannot be a generic for at least another year and a half.

Senator PRYOR. And you know, by all laws of economics, when a patent runs out and the other competitors, the other manufacturers, start picking up on all of these other drugs that have been under patent they could not produce, so they start producing them, changing the color, doing a lot of marketing and what have you, you would think the law of economics would say that these drugs are going to come down. That doesn't happen. The old pocketbook of the drug manufacturers, not your fault, but the drug manufacturers once again. That was a good question. Another comment or a question. In the very back, and then we'll come back down to the front.

FEMALE AUDIENCE MEMBER. Senator Pryor, you spoke about the upper class or the nonpoverished people in the country. What is being done in the Senate now to give people like myself who are trying to work and trying to survive with confidence continually suffering from inflation, high prices, to try to take care of elderly people—of our own elderly? When we get older, it seems that tax laws are geared to hurt the middle class or hurt the people like myself who are trying to do better. We can't take any deductions unless it's 2 percent over the annual income. What is being done in

the tax laws to help people like us who want to take care of our older parents but cannot afford it?

Senator PRYOR. Well, that's an excellent question and the answer is, very little is being done to address itself to this problem. There is some movement—we've heard just an inkling of discussion about it today. There's some movement toward some sort of—for example, of those individuals who are becoming the caretaker of some form of a tax incentive, some form of a reimbursement in elderly care. There's also—and this is a very controversial measure; it was vetoed by the President. This basically gears itself to the very young, and that is the legislation called parental leave, which is a program which guarantees to the individual worker a period, I believe, of how many weeks? Eight—60 days of—not paid by the employer, but have a job reserved for that period to look after not only a new born or an adopted child, but also in caring, I believe, for the elderly or the disabled. That is a very, very controversial piece of legislation.

I must say that business generally—not all business, but business generally has come out in strong opposition to this, especially small business. Even though the President has vetoed it, the House failed to override the veto last month. I think we're going to see that legislation come back. We should be doing more in just the area that you're talking about and we're not. Maybe we will. Another question or comment.

MALE AUDIENCE MEMBER. My comment is this. I'll soon be 83 years of age. I've never seen in my life that there was so much given from our government, the help that we're getting, Medicare, Medicaid, Social Security, food stamps, and all of that. We should be thankful for that. But listen, take care of yourself. They say your own community, but only you, and for you younger generation, save a little money because this other was never intended to support you for the rest of your life.

Senator PRYOR. Very good statement. Thank you. I guess that goes back to one of my original little thoughts I expressed here, or I tried to, the government can't do it all. We can't do it all. And I appreciate your comments. Another question or comment? Yes, sir. If you would please stand, please, sir.

MALE AUDIENCE MEMBER. Would you have time to answer a question on Social Security?

SENATOR PRYOR. If I know the answer to it. I've got some experts from Washington on this.

MALE AUDIENCE MEMBER. I can tell you, I was born in 1918.

Senator PRYOR. You're a Notch baby. You're looking at a real live Notch baby. Okay. I hope that we will take care of the Notch issue this year. There was some talk when we were about to get, as we thought, the so-called peace dividend that we could do it. The peace dividend has now gone to the Mid-East in the Saudi Desert. But I do—there's a lot of interest in trying to correct the problem this year, especially due to the fact that the Social Security trust fund is in surplus, and I hope we can this year. Thank you. Yes, sir. Yes. Or way back at the back, then we'll come right down here to the middle.

Mr. RALPH SCOTT. I'm wondering what ever happened to the Anti-Trust Division of the U.S. Department of Justice.

Senator PRYOR. I don't know. I don't have a lot to do about the Anti-Trust Division. This is not Ralph Scott, is it? Hello, Ralph, how are you? Ralph, whatever happened to it? You used to work for the Department of Justice and the FBI.

Mr. RALPH SCOTT. We enforced it in those days. I don't know of any action that's been brought under the Sherman or Trenton Anti-Trust Act in a long time. And if there is not a trust price fixing, I don't know what is.

Senator PRYOR. In the issue of drugs? Yes. And I say also in the issue of gasoline prices.

I think we need to invoke the Sherman Anti-Trust. By the way, Ralph Scott is a former FBI employee of many years and under Winthrop Rockefeller was the director of the Arkansas State Police, and a very fine citizen from Camden originally. And I've lost track of Ralph, and I have to come to a hearing like this. Ralph, we're both getting old, but anyway, here we are. Right here in the middle, please. Yes.

FEMALE AUDIENCE MEMBER. Senator Pryor, I'd like to ask your either ideas or request of your committee to explore the possibility in the national health care system, and if not national, then statewide that would be based on a system similar to Canada.

Senator PRYOR. All right. The Pepper Commission, of which I am a member, we've looked, I would say, at a rather exhaustive intensive study at the Canadian system, at the British system, and what have you. We've looked at the Scandinavian countries. Our system, as Dr. Lipschitz has said, is in danger. We're in a lot of trouble. I don't know where we go, but I do think in the health care system, I think that we're going to begin moving away from an employer-based system of health care. I think we're going to begin moving away from that. I think we will begin moving to a more universal coverage. But I don't think that I will live long enough to see a system of national health insurance, or what we might call socialized medicine that some of the other countries have. David would you comment on that? You're kind of an authority on that deal.

Dr. LIPSCHITZ. Well, I really am not sure that I'm the most appropriate person to talk about it because my feelings are somewhat to the left of center, so I would——

Senator PRYOR. That's all right. You can express them. It's a free country.

Dr. LIPSCHITZ. I would generally believe very strongly that we actually have an excellent model of universal health care in this country delivered to people who served in the armed forces. I can't emphasize enough how better off you are if you're old in America and a veteran, you just cannot compare the quality of service provided by the VA as compared to the private sector. At the same time, in the last 10 years, there has been a concerted effort to fragment and to minimize the VA. And in fact, there are some who maintain that there was a hidden conspiracy to eventually get rid of it. I would hope that actually the VA may be the model for the entire United States, and that eventually it will lead the way in providing some kind of universal care to all our citizens.

Senator PRYOR. Thank you. I am going to do something. I am going to ask the members of the Aging Committee staff—we have some—how many Aging Committee staff members do we have?

Now, I want Y'all to—I tell you what. I want y'all to come down here. Come on. Y'all come down here. You have been up there standing against the wall. I want y'all to come down, if you would, to the mike. And I've got a reason for this. They're going to kill me after I get through with this, but y'all come on down. And while you're getting down, I want you to come to this mike right here. Yes, sir, we'll have one more question or thought. Yes. sir.

MALE AUDIENCE MEMBER. Senator Pryor, the only thing I wanted to mention, the doctor—one of the things you asked the doctor, where we can get this information in regard to your diets. And in everything we have, nearly every clinic has a licensed dietitian in them, and all they need to do is to talk to our doctor and let him send them to those dietitians.

Senator PRYOR. That's good. Thank you for that. Thank you. Now, Portia, I want you to get out there with this group. No, no. Come on. I know this isn't normal or whatever, but I have a reason in doing this. Come on, Marcia, John.

Now, many times you call the Senate Aging Committee in Washington, and I have a theory that you ought to know who you're talking to. And so we're going to have a little deal trying to put names and faces together. Now, this is basically most of our staff. We still have quite a few up there in Washington who didn't get to make these trips, but some of these folks have come to Arkansas for the very, very first time, and we want them to get acquainted with everyone in Arkansas. They're going tomorrow to be a part of the State convention on aging, and they're going to be there 2 or 3 days. They're working around the State and traveling working with various communities. Now, I am going to just ask Portia—Portia, just ask everyone to come up to the mike. First you, Portia, as Director of the staff, and then let's ask—you say something, Portia, and then we'll ask each person to give their name and where they're from and how they got involved in this. I think that will be good.

Mrs. MITTELMAN. He is right. We really are going to kill him when we get back. I would just like to say that I am very, very proud to work with this group of people. They have been wonderful. And the hearing you've had today is the result of everyone's efforts. So I would personally like to give them a round of applause.

Ms. DREYER. Good afternoon. I'm Heather Dreyer, and I do work with housing and nutrition issues with the Committee. This is my first trip to Arkansas.

Senator PRYOR. Where are you from, Heather?

Ms. DREYER. I'm from Rhode Island.

Senator PRYOR. That's a long way from Arkansas, isn't it?

Ms. DREYER. And I've been with the Committee since January.

Senator PRYOR. Thank you, Heather. Kris.

Ms. PHILLIPS. You're right, Senator, we are going to kill you. I'm Kris Phillips. I'm the press secretary for the Committee, and I lived here for about 7 years before I went to Washington. And I took everyone last night to Grandpa's Catfish House in North Little Rock and we all had a wonderful time.

Senator PRYOR. And Kris is the one who took the lead in producing our film for us today. You will remember her from Channel 7. She used to be with Channel 7. Johnna.

Ms. GOGGANS. I'm Johnna Goggans, and I'm from Pine Bluff, AK, and I'm Kris Phillips' assistant, the press assistant.

Senator PRYOR. And you did an excellent job in the production of that film, too, and we appreciate it.

Ms. DIXON. Hi. My name is Ann Dixon, and I'm a native of Little Rock, AR. I moved to Washington in January of this year where I serve as the legislative correspondent for the Committee.

Senator PRYOR. Good. Thanks, Ann.

Ms. BODE. Hi. I'm Holly Bode. I'm from Ohio. I've been with the Aging Committee for about 5 years now. So in that time. I think I've done just about every issue. Right now, I'm concentrating on long-term care in hospitals, and I love to hear from people in Arkansas. It's been great working for Senator Pryor, and I encourage you all to call us. So thank you.

Ms. HOGUE. Hi. I'm Bonnie Hogue. I'm from North Carolina. I've been on the Aging Committee for about a year now, and I work on Medigap insurance. I understand a lot of you have been approached by different people, and call me if you have any questions or problems about that. And I'm sure happy to be in Arkansas. We enjoyed the catfish last night.

Ms. DRAYTON. Hi. I'm Chris Drayton. I'm from Virginia. I'm the Committee's chief clerk.

Senator PRYOR. She does the payroll. She's the most important one.

Ms. KINDERMANN. Hi. I'm Anna Kindermann. I'm from Maryland, and I've been with the committee only a short time, since May. But I've been working on the Older Americas Act and gearing up for the reauthorization. And I must say that this is the nicest bunch of people that I've ever met, here in Arkansas.

Senator PRYOR. Thank you. They are. John.

Mr. MONAHAN. I'm John Monahan. I've been working for Senator Pryor for about a year and a half, and I work on Older Americans Act and nutrition issues for the Aging Committee, and I'm originally from Chicago.

Senator PRYOR. Thank you, John.

Ms. LECKY. I'm Marcia Lecky. I'm from Little Rock. I taught at Hall High for 15 years, and most proud of the fact that Portia Mittelman was a student of mine the first year I taught and now she's my boss.

Senator PRYOR. Thank you. Thank all of you. And we appreciate the staff and we're proud of those who have come for the first time. We want to also thank Tammie Foreman, our wonderful court reporter, who is going to make a transcript available to those who write in and request it. Portia, any other comments I should say? John Pounders, you and the Baptist Medical Center, once again, thank you. This has been a very, very fine hearing, and your hospitality was great. Our meeting will now stand adjourned.

APPENDIX

MATERIAL RELATED TO HEARING

Item 1

Scat, Inc.

Little Rock, Arkansas - (501) 374-0123
Parris Towers Senior Center, 1800 Broadway, 72206
Cumberland Towers Senior Center, 311 E. 8th Street, 72202
Powell Towers Senior Center, 1010 Wolfe Street, 72202

B. J. BOWEN
EXECUTIVE DIRECTOR

A United Way Agcr

August 20, 1990

The Honorable David Pryor
Rm. 3030, Federal Office Bldg.
700 West Capitol
Little Rock, AR 72201

My dear Senator Pryor:

I am grateful for the opportunity to provide you with comments on the issues of Long Term Care in the 90's and share with you some of my concerns as a provider of services to older adults. I am also appreciative of the opportunity to be able to provide you with some suggestions that may be of assistance in resolving these problems.

The older adult population represents one of the largest and fastest growing segments of our adult population. With this continued growth rate the elderly will represent one of the most significant demographic changes this country will face over the next fifty (50) years. Elderly people are living longer and are generally healthier than their cohorts were twenty-five years ago. People in the 85+ age group are one of the fastes growing segments of the adult population. With the elderly population growing at the rate it is, there will be a continued need for the development of more community based services to meet the growing long-term care service needs of America's older adult population.

PROBLEMS IN NUTRITION:

1. Many elderly are on fixed and limited income ($500.00 or less per month) and cannot afford the basic food necessities for existance. I know of many elderly who have prescription cost that range from $100.00 to $225.00 per month for prescription drugs. By the time they pay for their drugs, rent, and utilities they do not have money left for food. Each time the elderly population receives an increase in social security benefits the cost of Medicare, groceries, etc. also increases, sometimes to the point that the dollar increase is already spent prior to the raise going into effect.

   Recommended Solutions

   A. For all elderly people aged 65+ who have an individual income of 10,000 or less, or married couples with a combined income of 20,000.00 or less a maximum limit of 1% should be placed on all food and drug expenses; I would suggest no taxes on food and drug expenses if I believed our legislators would pass a bill addressing this proposal.

Gray is Beautiful!

B. Elderly persons living in both rural and urban areas should be permitted to eat free at the public school cafeteria in their community. This would assure the elderly population in that community would be getting a nutritionally balanced daily meal. This would also provide a great opportunity for the elderly to give some volunteer time to the schools which would allow for socialization and enhancement of feelings of productivity and usefullness. In addition, if the federal restraints were relaxed, schools could send home delivered meals to the elderly living in the community who for one reason or another could not come to the school.

C. Increase the allotment of commodities being given to the elderly and AFDC recipients. During the last two years I have seen first hand commodities being cut from once a month to once per quarter. Elderly no longer receive cheese or rice--which many elderly existed on at the end of the month when their money ran out. "Why do we send food to so many foreign nations when we need to help our elderly first?" This is the question I hear over and over again.

PROBLEMS IN HEALTH CARE:

1. Many elderly cannot afford the high cost of prescription medications - especially medication for high blood pressure, diabetes, gastro-intestinal disorders, etc. Some elderly are spending as much as 25% of their monthly income on prescription medications; especially the elderly with more than one chronic illness.

   Recommended Solutions

   A. Develop a system that would provide a maximum out-of-pocket expense of $50.00 per month for elderly people with incomes of $10,000.00 per individual or $20,000.00 for married couple (the maximum out-of-pocket expenses for married couples would be $100.00 per month).

   B. Place limits on the cost of prescription prices charged by drug companies and pharmacists in this country. For some prescription medications Americans are paying as much as five (5) times more than Europeans are for the same drug.

2. Many elderly are going without quality health care because they do not have a doctor in their community or do not have a way to get to the doctor's office.

   Recommended Solutions

   A. Develop store front clinic in the community. These clinics could be conducted by health care professionals from some of the medical/nursing schools in the area and could be set up at a school or church, et.

   B. Increase funds from the federal and state level in transportation of elderly to clinics or doctors' offices.

3. Both rural and urban elderly have difficulty paying for the high cost of long term health care. I have a friend whose husband recently had major surgery. She contacted several aging programs in the community to get assistance in the care of her spouse when he returned home. She could not afford the minimal cost of $7.00 per hour for chore services, especially with a minimum of 15 hours per week. I have seen families loose their life savings purchasing services for an elderly family member with a debilitating illness.

   Recommended Solutions

   A. Increase federal allocations in the area of chore service and home health care - at the same time place elderly clients on a sliding scale fee for these services.

   B. Increase the length of time elderly persons can remain in the hospital for an illness. What I am seeing now is that people are being discharged quicker yet sicker from the hospital.

   C. Have stop gap measures that would curb out-of-pocket expenses for medical cost incurred by elderly people. The amount could be set at 50% of their savings or combined assetts.

PROBLEMS IN TRANSPORTATION:

1. Elderly are limited in transportation sevices available to them in both rural and urban areas. Because of difficulty in getting transportation many have been isolated socially and have missed medical appointments. Two years ago I was working with a client who had glaucoma. They missed three appointments with their eye specialists because transportation was not available - the person had to make reservations two weeks in advance and the driver did not (I believe would not) come into their apartment to pick them up.

   Recommended Solutions

   A. In rural communities allow school buses to pick up elderly and transport them to community senior centers. Also develop systems that would encourage churches and companies located in the area to transport elderly to doctors offices etc.

   B. Take money out of transportation services in urban areas and put it into rural communities; except in medical transportation. I see alot of duplication in the urban area regarding transportation to senior centers. I have three senior centers located at three (3) high rise retirement centers yet there are vans that come from other federally funded programs to take elderly to their facility although I provide the same services - this is a waste of time and money.

HOUSING PROBLEMS:

1. There is a growing need for long term and short term care facilities in rural and urban communities.

   Recommended Solutions

   A. Provide incentive to the private sector to provide low cost housing for our rural elderly population. This could be anything from a cottage setting (5 or 6 two bedroom houses) to multi-story retirement complexes. The rent could be subsidized with section 8 funds. (I would note that there are some problems I see with the current trends in high rise retirement centers who receive this type of funding: people who are younger than 62 are being admitted to these complexes due to being emotionally or physically handicapped. This has created a tremendous amount of tension with the older adults living in these buildings; not because of the condition of either party but because of the wide differences in age gaps-this should never have been allowed).

In closing, there are a few additional comments I would like to make regarding services to the elderly.

With the continued growth of the elderly population there will be an ongoing demand for health care services and with this demand we will experience more increases in health care costs. Everyone sees the need for improved long term care services, yet, where will the funds come from to provide these services? Some people have suggested increases in taxes while others favor reductions in defense spending in order to provide more funds for human services, and still others prefer to see how we can streamline our existing systems to create more funds for direct services.

One possible solution would be to look at the existing funding structure within our state system. Currently, as I understand the system, the Office on Aging and Adult Service receives state and federal funds for services to be provided to elderly persons in the state. The funds are then allocated to eight regional Area Agencies on Aging programs who then contract with community agencies for providing direct services--such as, chore services, transportation, nutrition, etc. Has anyone thought about abolishing the eigh Area Agency on Aging Agencies and consolidating them into one Single State Agency (SSA)? This may be a way to save a considerable amount of funds which are now being used for management and administrative overhead such as, rent, utilities, office operational cost, personnel and fringe benefits. The savings could be used for direct services. I tried to do some research to determine the actual cost of operating each of the AAA's, but due to the type of budgeting system used I was not able to obtain the data I needed. I would encourage your office to pursue this avenue of cutting overhead.

If you or your staff would like to discuss these issues further, please do not hesitate to contact me at my office (501) 374-0123.

Very Truely Yours,

B. J. Bowen
Executive Director

Item 2

CENTRAL ARKANSAS TRANSIT AUTHORITY

CAMMACK VILLAGE · LITTLE ROCK · MAUMELLE
NORTH LITTLE ROCK · PULASKI COUNTY · SHERWOOD

August 23, 1990

Ms. Portia Mittleman
Staff Director and Chief Counsel
Special Senate Committee on Aging
Dirksen Building
Washington, D.C., 20510

Dear Ms. Mittleman:

I recently attended Senator Pryor's committee's public hearing in Little Rock. It was an important session and many problems and possible solutions were discussed.

I would like to submit the attached statement to be included in the record of the hearing. It is offered by CATA on behalf of the elderly persons in the Little Rock-North Little Rock area.

Thank you for the opportunity to have our views become part of the record.

Sincerely,

Keith Jones
Executive Director

enclosure

copy: Arkansas Transit Association

CAT

408 Pyramid Place ☐ 2nd & Center Streets ☐ Little Rock, AR 72201 ☐ 501/375-6717

STATEMENT TO THE SPECIAL SENATE COMMITTEE ON AGING
HONORABLE DAVID PRYOR, CHAIRMAN
August 21, 1990
Little Rock, Arkansas
Gilbreath Conference Facility
Baptist Medical Center

FROM
CENTRAL ARKANSAS TRANSIT AUTHORITY
CHRIS BUTTON, CHAIRMAN OF THE BOARD
KEITH JONES, EXECUTIVE DIRECTOR

Elderly persons throughout Arkansas have a lack of choice when it comes to transportation needs. It is common knowledge that most elderly persons in rural Arkansas have transit or paratransit options only when they are aligned with a specific social service program. There will be ample testimony today from the service providers and transportation agencies representing that segment of Arkansas' population. As the public transportation provider in Pulaski County, we want to provide a statement of the needs in the urbanized areas.

Many elderly persons in the Little Rock area are just as isolated as their counterparts in the rural areas. With all the transportation service provided by CATA's fixed route system and its paratransit service "Wheels", this may seem like a contradiction. However, after years of declining Federal support and lack of local dedicated funds, CATA's service have become focused on only the higher volume service, which is the journey to work, and in most cases only the journey to work in downtown Little Rock. Even though their needs are important, the nature of their travel needs has become hard to serve with a limited fixed route system. Elderly persons don't travel to the same place every day, and they don't travel on a predictable schedule, especially for medical trips. The wait times and walking distances required to use the bus routes are not always compatible with the physical conditions of the elderly.

An example of the hard choices we have to make involves service to the Good Shepherd residential center near here. This center, which is home to hundreds of residents, is served by our Baptist Med Center bus route. Because it is some distance from our main route on Kanis Road, the bus doesn't go there every trip. Before last year it did provide periodic service from early in the morning to the end of the day. It was used by residents to get to this hospital and its many doctors offices and also to Doctor's Hospital and the shopping malls on University Avenue. Faced with the pressure to reduce our operating expenses and provide service with fewer and fewer buses, last year we

had to reduce service from 11 trips a day to 8 trips. There is no direct service to the other hospitals or the malls. The real story of the cuts is in the hours of service. We now serve Good Shepherd only between the hours of 9:40 and 2:20 p.m. Persons with afternoon medical appointments simply can't use this low-cost service anymore.

CATA operates a 50-bus system throughout most parts of the County. We serve over 10,000 passenger trips every day. CATA routes pass near the major high-rise housing complexes for the elderly. Our routes also serve the major medical centers of the area--both Veteran's hospitals, the UA Med Center, Baptist Medical Center, St. Vincents' Medical Center, Baptist Memorial Hospital, and Doctor's Hospital, to name the major facilities. We offer service at a reduced fare for persons over 65. It only costs 40c to ride the bus, or $12.00 a month for an unlimited ride pass. Only 10 to 15% of our riders are over 65, however, and we know the need for service exceeds that. Riders must wait for the buses without shelter from the elements. Many trips involve a transfer downtown, which makes for a long trip and an uncomfortable wait on the downtown sidewalks.

Recognizing that elderly persons and persons with disabilities are not adequately served by the fixed route system, in 1988 CATA began a door-to-door service using vans and minibuses. It is operated by the Pulaski County Red Cross. There was Federal assistance to buy the vehicles,but there is no special Federal assistance for the service. CATA has been using its limited funds for the operation costs, but to cover the costs we have to charge a fare much higher than the normal bus fare. It costs $3.50 to ride Wheels. Athough it is being used by over 1500 persons monthly, we realize that the cost keeps it from being an alternative for persons on fixed incomes. "Wheels" is a beginning to a service that is more appropriate to the needs of elderly and disabled persons.

In summary, there is a need for government assistance to public transportation throughout the state. The travel patterns of elderly persons are not conducive to high-volume cost-efficient transporation service. We welcome the opportunity to provide input into this hearing, and stand ready to work to provide the kind of transporation services needed by elderly persons and all Arkansans throughout the State.

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